Care for You
Home Health Care Agency
1650 W Market Street Suite 11
Akron, Ohio 44313
Office: 234.334.0185
Fax: 234.281.0252
Email: timesheet@careforyouhha.com

REMINDER: TIME SHEETS DUE EVERY MONDAY BY NOON!!!

PRINT CONSUMER NAME: _____

PRINT HOME HEATLH AIDE NAME: _____

HHA IDENTIFICATION NUMBER: _____

		1ST SHIFT		2ND SHIFT				
DATE	DAY	Time In	Time Out	Time In	Time Out	• Daily Totals	Client Signature	HHA Signature
MM/DD/YYYY		*HH:MM (AM/PM)*	*HH:MM (AM/PM)*	*HH:MM (AM/PM)*	*HH:MM (AM/PM)*			
	Monday							
	Tuesday							
	Wednesday							
	Thursday							
	Friday							
	Saturday							
	Sunday							

Note: All Time Sheets must be properly formatted and filled out correctly and completely or they will not be accepted by care for you *If you have any questions relating to the policies and procedures pertaining to Time Sheets please contact* care for you *immediately. If the condition of the Consumer changes in any way, please contact* Care for You *immediately and notify the staff of the change. If the Consumer has any questions, please assist them in contacting EmanciCare immediately.*

Sum and Enter Total Hours for Week >>>

HOME HEALTH AIDE DAILY ACTIVITY REPORT

PERSONAL CARE SERVICES	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Bathing: Tub/Shower assist							
Bathing: Sponge Bath (Bed or Chair)							
Hygiene: General Grooming, Skin Care lotion rub							
Hygiene: Shampooing, Hair Care, Styling							
Hygiene: Hand, Foot and Nail Care file only							
Hygiene: Oral Care and Denture Care							
Hygiene: Elimination/Ostomy Assistance , catheter care							
Companion: Activities (E) sort to appointments							
Hoyer lift Dressed/Undressed							
Mobility: Walker/Cane Assistance Wheel Chair							
Mobility: Range of Motion Arm (Right / Left)							
Mobility: Range of Motion Leg (Right / Left)							
Other: emptying bedside commode							

PERSONAL CARE ANCILLARY	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Reminder: Medication Reminder							
Monitoring: Skin Condition							
Enter Skin Condition: Dry, Irritated, Bruised, Broken, Itchy							
Monitoring: Swelling							
Enter Swelling Area: Hands, Feet, Arms, Legs, Abdomen							
Enter Other Conditions Noted							

Note: Please use the reverse side of this time sheet to record additional comments relating to the Consumer.

HOME MAKING SERVICES	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Housekeeping: General Cleaning, Trash Removal							
Housekeeping: Bedding Services change Linen/ make-up bedding							
Meal Prep: B/L/D/S (F)eeding							
Errands: Grocery/Other Shopping medication pick-up							
Laundry: Wash/Fold/Put Away Ironing clothes							
Other Home Making Service Performed							

Please use this letters to determine how you provided services:

R=Refused
A=Assist
T=Total Assist

ALL TIMESHEET MUST BE TURNED IN BY 12 NOON INTO OUR OFFICE IF THEY ARE LATE ALL HOURS FOR THAT LATE TIMESHEETS WLL BE ADDED TO NEXT PAYCHECK. IF YOU SUMBIT YOUR TIMESHEETS WITHOUT CLIENT SIGNATURES OR YOUR SIGNATURE, NO DATES YOU PROVIDED SERVICES YOU WILL NOT BE PAID UNTIL WE RECIEVE ALL TIMESHEETS THAT ARE FILLED OUT CORRECTLY. NO EXCUSES !!!!!!!!!!!!!!!!!!!!

Notes: _____

WEEKLY TIME SHEET SIGNATURE

Consumer Signature: _____

My signature on this Time Sheet is my consent and acknowledgement that all information contained on this Time Sheet is true and accurate. I agree that all services indicated were performed on the dates specified to my satisfaction and that I have no complaints, issues or concerns regarding services performed.

Home Health Aide Signature: _____

My signature on this Time Sheet is my certification that I performed all of the services indicated to the Consumer's satisfaction. I also certify that I have notified Care for you regarding any changes in the Consumer's condition, whether they were traveling and/or admitted or discharged from the hospital.