

Care for You  
 Home Health Care Agency  
 1650 W Market Street Suite 11  
 Akron, Ohio 44313  
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 Fax: 234.281.0252  
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**REMINDER: TIME SHEETS DUE EVERY MONDAY BY NOON!!!**

PRINT CONSUMER NAME: \_\_\_\_\_

PRINT HOME HEALTH AIDE NAME: \_\_\_\_\_

HHA IDENTIFICATION NUMBER: \_\_\_\_\_

DATE	DAY	1ST SHIFT		2ND SHIFT		3RD SHIFT		4TH SHIFT		TOTALS
		Time In HH:MM (AM/PM)	Time Out HH:MM (AM/PM)	Time In HH:MM (AM/PM)	Time Out HH:MM (AM/PM)	Time In HH:MM (AM/PM)	Time Out HH:MM (AM/PM)	Time In HH:MM (AM/PM)	Time Out HH:MM (AM/PM)	Daily Totals
MM/DD/YYYY										
	Sunday									
	Monday									
	Tuesday									
	Wednesday									
	Thursday									
	Friday									
	Saturday									

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 EmancipCare immediately.

Sum and Enter Total Hours for Week >>>

**HOME HEALTH AIDE DAILY ACTIVITY REPORT**

PERSONAL CARE SERVICES	SUN	MON	TUE	WED	THU	FRI	SAT
Bathing: Tub or Shower Assistance							
Bathing: Sponge Bath (Bed or Chair)							
Hygiene: General Grooming, Skin Care							
Hygiene: Shampooing, Hair Care, Styling							
Hygiene: Hand, Foot and Nail Care							
Hygiene: Oral Care and Denture Care							
Hygiene: Elimination/Ostomy Assistance							
Mobility: General Activity Assistance							
Mobility: Ambulation Wheel Chair							
Mobility: Walker/Cane Assistance							
Mobility: Range of Motion Arm (Right / Left)							
Mobility: Range of Motion Leg (Right / Left)							
Other:							

PERSONAL CARE ANCILLARY	SUN	MON	TUE	WED	THU	FRI	SAT
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	SUN	MON	TUE	WED	THU	FRI	SAT
Housekeeping: General Cleaning, Trash Removal							
Housekeeping: Bedding Services							
Errands: Medication Pickup							
Errands: Grocery/Other Shopping							
Laundry: Wash/Fold/Put Away							
Other Home Making Service Performed							

**DAILY TIME SHEET SIGN-OFF**

	Consumer Signature	Home Health Aide Signature
Sunday	_____	_____
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____

**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.