

CARINGHANDS HOME HEALTH CARE INC.

TELE: 651-207-8245 FAX :651-493-6975

Home Making / Companion HIS ,Time Sheet

| DATES OF SERVICE MM/DD/YY | Thursday | Friday | Saturday | Sunday | Monday | Tuesday | Wednesday |
|--|-----------------------|-------------|--------------------|-----------------|----------|-----------------------------|-----------|
| | | | | | | | |
| TIME IN (Circle AM/PM) | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| TIME Out (Circle AM/PM) | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| Complate the activities listed below according to the Homemaker Assignment Sheet .For additional changes contact supervisor . To ensure payment you MUST write your INITIALS next to all activities for each date you prove care | | | | | | | |
| Vacuum | | | | | | | |
| Laundry | | | | | | | |
| Kitchen | | | | | | | |
| Wash Dishes | | | | | | | |
| Clean Rerigerator | | | | | | | |
| Empty Garbage | | | | | | | |
| Fold Clothes | | | | | | | |
| Put Away Clothes | | | | | | | |
| Living Room | | | | | | | |
| Dust | | | | | | | |
| Bathroom | | | | | | | |
| Clean Toilet/Sink | | | | | | | |
| Clean Shower/Tub | | | | | | | |
| Change Bed Linen | | | | | | | |
| Groceries Shopping | | | | | | | |
| Socialization | | | | | | | |
| Meal Preparation | | | | | | | |
| Other | | | | | | | |
| Daily Total Hours | | | | | | | |
| By signing below and completing all information each employee certifies that all information is accurate and correct. It is a federal crime to prove false information for billing Medical AssistanceAnd Medicaid | | | | | | Total Hours For Week | |
| RECIPIENT NAME | (First , Last) | | Client DATE | OF BIRTH | | | |
| | | | | | | | |
| Client Signature | | | | DATE | | | |
| | | | | | | | |
| Employee First And Last : | | | | | | | |
| | | | | | | | |
| Employee Signature : | | DATE | | | | | |
| | | | | | | | |