CARING PROFESSIONALS HOMECARE

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HOMEMAKING
2 WEEK/TIMESHEET

EMPLOYEE NAME: _____

CLIENT NAME: _____ **PERIOD COVERED:** ___/___20___TO ___/___20___

Please write your initials next to all the activities you provide on a daily basis. Initial ONLY the activities that pertain to the type of the Homemaking your client has, as there are 3 different types of homemaking.

Activities	MON	TUES	WED	THUR	FRI	SAT	SUN	MON	TUES	WED	THUR	FRI	SAT	SUN
Homemaking w/Activities Of Daily Living (TG)								**Homemaking w/Activities Of Daily Living (TG)**						
Bathing														
Toileting														
Grooming														
Eating														
Ambulating														
Home Management (TF)								**Home Management (TF)**						
Laundry														
Meal Prep														
Shopping														
Simple Repairs														
Arrange Transportation														
Basic Cleaning Services (S5130)								**Basic Cleaning Services (S5130)**						
Wash & Dry Dishes														
Dust Furniture														
Floors & Carpet														
Empty Garbage														
Clean Mirrors														
Clean Bathrooms														
Make Bed														
Clean Refrigerator														
Wipe Down Counters														
Laundry														

☐ CHECK HERE IF YOU HAVE ADDITIONAL CLIENT OBSERVATIONS / CONCERNS. PLEASE DOCUMENT THESE ON BACK OF THE WHITE CHARTING SHEET AND NOTIFY YOUR SUPERVISOR OF ANY UNSUAL BEHAVIORS / OBSERVATIONS / CONCERNS IMMEDIATELY.

DAY	DATE	TIME WORKED IN	TIME WORKED OUT	DAILY TOTAL TIME IN HOURS & MINUTES (HH:MM)
MONDAY	/ /20___	AM PM	AM PM	
TUESDAY	/ /20___	AM PM	AM PM	
WEDNESDAY	/ /20___	AM PM	AM PM	
THURSDAY	/ /20___	AM PM	AM PM	
FRIDAY	/ /20___	AM PM	AM PM	
SATURDAY	/ /20___	AM PM	AM PM	
SUNDAY	/ /20___	AM PM	AM PM	
MONDAY	/ /20___	AM PM	AM PM	
TUESDAY	/ /20___	AM PM	AM PM	
WEDNESDAY	/ /20___	AM PM	AM PM	
THURSDAY	/ /20___	AM PM	AM PM	
FRIDAY	/ /20___	AM PM	AM PM	
SATURDAY	/ /20___	AM PM	AM PM	
SUNDAY	/ /20___	AM PM	AM PM	
		TOTAL HOURS & MINUTES		

Acknowledgement and Required Signatures

After the employee has completed the 2 week pay period, the client/recipient should **draw a line** through the dates and times he/she did not receive assistance. Both client (his/her responsible party) and employee must sign this timesheet in order for this timesheet to be valid.

IT IS A FEDERAL CRIME TO PROVIDE FALSE INFORMATION ON HOMEMAKING BILLINGS FOR MEDICAL ASSISTANCE PAYMENT.

RECIPIENT / CLIENT NAME	DOB OR MA#
RECIPIENT / RESPONSIBLE PARTY SIGNATURE	DATE
EMPLOYEE NAME	
EMPLOYEE SIGNATURE	DATE

Revision Date: 12/10/15 DOC

Is there a change in the employee's or client phone number? Y__ N __ Please update_____

Is there a change in the employee's or client's address? Y__ N__ Please update _____