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# TIME SHEET

CHECK ONE  
SERVICE TYPE:  
☐ PERSONAL CARE  
☐ HOME MAKING / CMP

CLIENT NAME: \_\_\_\_\_

Important Information for Client: By signing this form, client certifies that hours shown are correct and work was done satisfactory. I authorize to be charged or billed for services rendered for this week.

| DATE                                       | DAY  | START | FINISH | START | FINISH | TOTAL<br>HOURS WORKED | MILEAGE | CLIENT SIGNATURE<br>(TO BE SIGNED DAILY) |
|--|------|-------|--------|-------|--------|-----------------------|---------|--|
|  | Mon  |       |        |       |        |                       |         |  |
|  | Tues |       |        |       |        |                       |         |  |
|  | Wed  |       |        |       |        |                       |         |  |
|  | Thur |       |        |       |        |                       |         |  |
|  | Fri  |       |        |       |        |                       |         |  |
|  | Sat  |       |        |       |        |                       |         |  |
|  | Sun  |       |        |       |        |                       |         |  |
| TOTAL HOURS WORKED / BILLABLE FOR THE WEEK |      |       |        |       |        |                       |         |  |

| ACTIVITIES                            | Mon | Tues | Wed | Thur | Fri | Sat | Sun | Comments With Date |
|---------------------------------------|-----|------|-----|------|-----|-----|-----|--------------------|
| <b>PERSONAL CARE</b>                  |     |      |     |      |     |     |     |                    |
| Bathing                               |     |      |     |      |     |     |     |                    |
| Dressing                              |     |      |     |      |     |     |     |                    |
| Ambulation                            |     |      |     |      |     |     |     |                    |
| Transfers                             |     |      |     |      |     |     |     |                    |
| Feeding                               |     |      |     |      |     |     |     |                    |
| Toileting                             |     |      |     |      |     |     |     |                    |
| Incontinence                          |     |      |     |      |     |     |     |                    |
| Shampoo                               |     |      |     |      |     |     |     |                    |
| Oral Care                             |     |      |     |      |     |     |     |                    |
| Hair Care                             |     |      |     |      |     |     |     |                    |
| Skin Care                             |     |      |     |      |     |     |     |                    |
| Hand/Foot Care                        |     |      |     |      |     |     |     |                    |
| Shave                                 |     |      |     |      |     |     |     |                    |
| Assist With Meals                     |     |      |     |      |     |     |     |                    |
| Positioning                           |     |      |     |      |     |     |     |                    |
| ROM Exercise                          |     |      |     |      |     |     |     |                    |
| Vital Signs                           |     |      |     |      |     |     |     |                    |
| <b>HOMEMAKING SUPPORTIVE SERVICES</b> |     |      |     |      |     |     |     |                    |
| Companionship                         |     |      |     |      |     |     |     |                    |
| Remind Medications                    |     |      |     |      |     |     |     |                    |
| Meal Preparations                     |     |      |     |      |     |     |     |                    |
| Linen Changes                         |     |      |     |      |     |     |     |                    |
| Bed Making                            |     |      |     |      |     |     |     |                    |
| Laundry                               |     |      |     |      |     |     |     |                    |
| Vacuum                                |     |      |     |      |     |     |     |                    |
| Dusting                               |     |      |     |      |     |     |     |                    |
| Mop/Sweep                             |     |      |     |      |     |     |     |                    |
| Clean Bathroom                        |     |      |     |      |     |     |     |                    |
| Clean Kitchen                         |     |      |     |      |     |     |     |                    |
| Shopping/Errands                      |     |      |     |      |     |     |     |                    |

I have reported to management all injuries and illnesses arising from this assignment and I have not been subject to harassment in the workplace.

PLEASE CHECK ONE: DISCIPLINE ☐ HHA ☐ CNA ☐ LPN ☐ RN

COUNTY ☐ BROWARD ☐ DADE

Print Caregiver Name: \_\_\_\_\_ Caregiver Signature: \_\_\_\_\_

Date: \_\_\_\_\_

WHITE COPY - AGENCY

YELLOW COPY - CAREGIVER

# Sample Home Health Timesheet

**Minjie Lin**

A red circular graphic with a gradient, appearing as a semi-circle or a partial circle, located to the right of the name bar.

**Sample Home Health Timesheet:**

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