

# HOLISTIC HOME HEALTH CARE & HOSPICE – Personal Care Worker Timesheet & Charting

PATIENT NAME & # \_\_\_\_\_ EMPLOYEE NAME & # \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

EMPLOYEE MUST FILL OUT CHART AND TIMESHEET COMPLETELY. Write the date MM/DD/YY AND visit time in & visit time out for EACH shift worked.

**INCOMPLETE & NONORIGINAL TIMESHEETS MISSING ANY INFORMATION ARE NOT VALID AND WILL NOT BE ACCEPTED!**

DATE: DAY	/ /		/ /		/ /		/ /		/ /		/ /		TOTAL
	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		
	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	
Travel Start (coming)													
Travel End (coming)													
Visit Time In:													
Visit Time Out:													
Travel Start (leaving)													
Travel End (leaving)													
TOTAL VISIT													
TOTAL VISIT													

**ACKNOWLEDGEMENT AND REQUIRED SIGNATURES:** Review the completed time sheet for accuracy before signing.  
*It is a federal crime to provide false information on billings for Medical Assistance payment.*  
 Your signature **verifies** the time and services entered above are **accurate** and that the services were performed **as specified in the Care Plan.**

EMPLOYEE SIGNATURE: \_\_\_\_\_ DAY & DATE: \_\_\_\_\_

CLIENT SIGNATURE: \_\_\_\_\_ DAY & DATE: \_\_\_\_\_

EMPLOYEE INITIAL/CHECKMARK/MARK TIME OF THE SERVICES PROVIDED AT THE TIME OF VISIT	Sun		Mon		Tue		Wed		Thurs.		Fri		Sat	
	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
<b>PERSONAL CARE:</b>														
BATH – BED/ PARTIAL/SHOWER/TUB														
ORAL HYGIENE (BRUSH TEETH/CLEAN DENTURES)														
HAIR CARE/SHAMPOO/COMBING														
SHAVE														
NAIL CARE														
PREVENTATIVE SKIN CARE														
LOTION														
ASSIST WITH DRESSING														
TEDS STOCKING														
ASSIST WITH EATING														
CHANGE POSITION/ TURN														
TRANSFER – TRANSFER BELT/HOYER LIFT														
ASSIST WITH AMBULATION: CANE/WALKER/ W/C														
RANGE OF MOTION EXERCISES (ACTIVE) (PASSIVE)														
ASSIST WITH SPLIT/BRACE														
SAFETY PRECAUTIONS														
ASSIST WITH TOILETING														
CATHETER CARE/EMPTY BAG/ PERI CARE														
BOWEL PROGRAM: YES NO														
BOWEL MOVEMENT: YES NO														
INCONTINENCE/ CHANGE DIAPERS/PERI-CARE														
ASSIST WITH MEDICATIONS														
MEDICATION REMINDER														
OTHER:														
<b>HOMEMAKING:</b>														
LINEN CHANGE														
LIGHT HOUSEKEEPING														
LAUNDRY/GROCERY SHOPPING														
MEAL PREPARATION														
OTHER:														
<b>SUPPORTIVE CARE:</b>														
SOCIAL/ RECREATION														
SHOPPING														
ERRANDS														
TRANSPORTATION														
OTHER:														

EMPLOYEE SIGNATURE: \_\_\_\_\_ DAY&DATE: \_\_\_\_\_ / /

PATIENT SIGNATURE: \_\_\_\_\_ DAY&DATE: \_\_\_\_\_ / /