**TIMESHEET**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pay Date Week: Sunday\_\_\_\_\_\_\_\_\_ To Saturday\_\_\_\_\_\_\_\_\_\_\_ Week Ending:\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | |
| **Day** | **Date** | **VISITS** | | | | | | | | | | **Total** | **Client Sign** | | | | **Employee Sign** | | | | |
|  |  | **Time In** | | | | | | **Time Out** | | | |  |  | | | |  | | | | |
| **Sun** |  |  | | | | | |  | | | |  |  | | | |  | | | | |
| **Mon** |  |  | | | | | |  | | | |  |  | | | |  | | | | |
| **Tue** |  |  | | | | | |  | | | |  |  | | | |  | | | | |
| **Wed** |  |  | | | | | |  | | | |  |  | | | |  | | | | |
| **Thur** |  |  | | | | | |  | | | |  |  | | | |  | | | | |
| **Fri** |  |  | | | | | |  | | | |  |  | | | |  | | | | |
| **Sat** |  |  | | | | | |  | | | |  |  | | | |  | | | | |
| **\_\_\_MC\_\_\_MD\_\_\_Waiver \_\_\_Passport\_\_\_Senior Option\_\_Insurance\_\_\_Private Pay\_\_\_Other.**  **Total Wkly Hrs**\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **PERSONAL CARE** | | | **S** | **M** | **T** | **W** | **T** | | **F** | **S** | **Elimination** | | | **S** | **M** | **T** | | **W** | **T** | **F** | **S** |
| Assist W/Bath-Bed/Tub/Shower | | |  |  |  |  |  | |  |  | Bedroom (Toilet, Tub, Skincare) | | |  |  |  | |  |  |  |  |
| Hair Care/Shampoo | | |  |  |  |  |  | |  |  | Bedside Commode | | |  |  |  | |  |  |  |  |
| Shave | | |  |  |  |  |  | |  |  | Bedpan/Urinal | | |  |  |  | |  |  |  |  |
| Skin Care/Back Care | | |  |  |  |  |  | |  |  | Catheter Bag | | |  |  |  | |  |  |  |  |
| Nail Care | | |  |  |  |  |  | |  |  | Record Output | | |  |  |  | |  |  |  |  |
| Foot Care | | |  |  |  |  |  | |  |  | Incontinence Care | | |  |  |  | |  |  |  |  |
| Oral Hygiene | | |  |  |  |  |  | |  |  | Empty Colostomy Bag | | |  |  |  | |  |  |  |  |
| Assist W/Dressing | | |  |  |  |  |  | |  |  | Bowel Movement | | |  |  |  | |  |  |  |  |
| **NUTRITION** | | |  |  |  |  |  | |  |  | **MOBILITY** | | |  |  |  | |  |  |  |  |
| Diet/Record Intake | | |  |  |  |  |  | |  |  | Transfer Chair/Commode | | |  |  |  | |  |  |  |  |
| Meal Prep. Full | | |  |  |  |  |  | |  |  | Assist W/Ambulation | | |  |  |  | |  |  |  |  |
| Assist W/ Feeding | | |  |  |  |  |  | |  |  | Encourage Coughing | | |  |  |  | |  |  |  |  |
| Encourage Fluids/Record Intake | | |  |  |  |  |  | |  |  | Deep Breathing | | |  |  |  | |  |  |  |  |
| **HOUSEKEEPING** | | |  |  |  |  |  | |  |  | Turn & Position | | |  |  |  | |  |  |  |  |
| Grocery Shopping/Prescription PU | | |  |  |  |  |  | |  |  | **TREATMENTS** | | |  |  |  | |  |  |  |  |
| Make Bed/Change Linen | | |  |  |  |  |  | |  |  | Non Sterile Dressing | | |  |  |  | |  |  |  |  |
| Tidy Work Area/Trash Removal | | |  |  |  |  |  | |  |  | Temperature/Respirations | | |  |  |  | |  |  |  |  |
| Clear Pathways | | |  |  |  |  |  | |  |  | Pulse/Blood Pressure | | |  |  |  | |  |  |  |  |
| Laundry | | |  |  |  |  |  | |  |  | Medication Reminder (Verbal) | | |  |  |  | |  |  |  |  |
| Vacuum | | |  |  |  |  |  | |  |  | Other: | | |  |  |  | |  |  |  |  |
| Sweep | | |  |  |  |  |  | |  |  |  | | |  |  |  | |  |  |  |  |
| Wet Mop | | |  |  |  |  |  | |  |  | Other: | | |  |  |  | |  |  |  |  |
| Dusting | | |  |  |  |  |  | |  |  |  | | |  |  |  | |  |  |  |  |
| Dishes | | |  |  |  |  |  | |  |  |  | | |  |  |  | |  |  |  |  |
| Refrigerator | | |  |  |  |  |  | |  |  |  | | |  |  |  | |  |  |  |  |
| Bathroom | | |  |  |  |  |  | |  |  |  | | |  |  |  | |  |  |  |  |
| Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_ Aide’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Please Print) (Please Print) | | | | | | | | | | | | | | | | | | | | | |

**\***All Timesheets are to be turned into the office every Tuesday by 5:00 pm. Timesheets submitted after the deadline will be held until the following pay period.**\***Please make certain that timesheets are completed entirely, accurately and that they are legible. Aides must sign with their **FULL NAME**. No **SCRATCH-OUTS**. No **WHITE-OUT**. If you make a mistake, draw a single line through it, initial it and make your correction. This is the property of A-Plus Home Health Care Agency LLC. The form and information therein, is confidential and proprietary.