



CONSUMER NAME: _____

EMPLOYEE NAME: _____

Place a ✓ mark under date of care only for activities completed.

Pay Period Start Date:						
Pay Period End Date:						
Week 1	Date	Time in	Time Out	Break	Hours Worked	Client/Auth. Rep Signature
Sun						
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						

Week 1 Total hours → Hours

Week 2	Date	Time in	Time Out	Break	Hours Worked	Client/Auth. Rep Signature
Sun						
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						

Week 2 Total hours → Hours

Two weeks Total hours: Hours

Employee Sign: _____ Date: ____/____/____

Client or: _____ Date: ____/____/____

Authorized Rep sign

Consumer Notice: By your signature above, you certify that the hours are accurate and that care was provided on the dates mentioned above.

Employee Notice: By your signature above, you certify that the hours posted in this timesheet are accurate and that you worked according to Service Plan within authorized units. You also agree to reimburse the amount if you have provided false record on this timesheet or you have been overpaid due to technical error.

Activities	WEEK 1							WEEK 2						
	S	M	T	W	T	F	S	S	M	T	W	T	F	S
Bathing														
Hair Care														
Dressing														
Lotion/Ointment														
Meal preparation														
Eating/Drinking														
Laundry														
Light Housekeeping														
Shopping														
Medication Reminder														
Reading/Writing														
Managing Finances														
Social/Leisure Activities														
Telephone use														
Securing Transportation														
Appointment Scheduling														
Caring Personal Possessions														
Obtaining Seasonal Clothing														
Using a Prosthetic Device														
Ambulating														
Range of Motion														
Supervised walks														
Supervision/Coaching/Cueing														
Toileting														
Bowel/Bladder Management														
Transfers														
Incontinence Care														
Catheter Care														
Wound Care														
G-tube Feedings														
Other														

Progress Note Comments: _____

Email: info@creativehomecare.net

FAX: 717-558-4344

County: _____

- AmeriHealth Caritas
 PA Health & Wellness
 UPMC CHC
 Keystone First CHC