EMPLOYEE TIMESHEET

EMPLOYEE NAME:

Week Ending

DATES

COVID-19 SYMPTOM FREE						
OFFICE HOURS	**Mon**	**Tues**	**Weds**	**Thurs**	**Fri**	**WEEK TOTAL**
Time In						
Time Out						
Holiday						
Vacation						
Sick Time						
Other						
TOTAL						

COVID-19 SYMPTOM FREE						
OFFICE HOURS	**Mon**	**Tues**	**Weds**	**Thurs**	**Fri**	**WEEK TOTAL**
Time In						
Time Out						
Holiday						
Vacation						
Sick Time						
Other						
TOTAL						

Employee signature: _____

Supervisor signature: _____

ICK-Assurance Home Health Care, Inc.

960 South Street, Fitchburg MA 01420 ~ Phone 978-342-0081 ~ Fax 800-560-3471

Employee's Name: _____ Pay Period: _____ to _____

Client's Name: _____

Please check all appropriate boxes for care given on each day of service—put R in on appropriate box if client refuses care on any day of service. Employee MUST FOLLOW CARE PLAN.

Date														
	Sun	Sun	Mon	Mon	Tue	Tue	Wed	Wed	Thur	Thur	Fri	Fri	Sat	Sat
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Time In														
Time Out														
COVID SYMPTOM-FREE (check box)														

PERSONAL CARE A.M.	S	M	T	W	Th	F	S		**PERSONAL CARE P.M.**	S	M	T	W	T	F	S
Bed Bath									Bed Bath							
Assist with Chair Bath									Assist with Chair Bath							
Tub Bath									Tub Bath							
Shower									Shower							
Shower w/Chair									Shower w/chair							
Shampoo hair									Shampoo hair							
Nail Care									Nail Care							
Hair Care/Comb hair									Hair Care/Comb Hair							
Oral Care									Oral Care							
Skin Care									Skin Care							
Peri care									Peri Care							
Shave									Shave							
Assist with dressing									Assist with dressing							
Medication reminder									Medication reminder							
ELIMINATIONS									**ELIMNATIONS**							
Assist with bed pan/urinal									Assist with bed pan/urinal							
Assist with BSC									Assist with BSC							
Incontinence Care									Incontinence Care							
Empty drainage Bag									Empty drainage Bag							
Record bowel movement									Record bowel movement							
Catheter Care									Catheter Care							
ACTIVITY									**ACTIVITY**							
Dangle on side of bed									Dangle on side of bed							
Turn and position									Turn and position							
Assist with transfer									Assist with transfer							
Range of motion									Range of motion							
Assist with Ambulation									Assist with Ambulation							
Equipment Care									Equipment Care							
HOUSEHOLD TASK									**HOUSEHOLD TASK**							
Make Bed									Make Bed							
Change Linen									Change Linen							
Light housekeeping									Light housekeeping							
NUTRITION									**NUTRITION**							
Meal Set-up									Meal Set-up							
Assist with Feeding									Assist with Feeding							

Total number of hours: _____

Employee Signature: _____

Client Daily Signature:

MONDAY: _____

TUESDAY: _____

WEDNESDAY: _____

THURSDAY: _____

FRIDAY: _____

SATURDAY: _____

SUNDAY: _____

Masshealth Waiver Weekly Visit Timesheet

Pay Period _____ to _____

Employee's Name *(Last, First):* _____

Patient's Name *(Last, First):*_____

Patient's Address: _____

Please check all appropriate boxes for care given on each day of service – put R in on appropriate box if patient refuses care on any day of service. Employee MUST FOLLOW CARE PLAN EXACTLY AS WRITTEN.

	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
Time In							
Time Out							
HHA							
Companion							
Home- maker							
Personal Care							
TOTAL HOURS							
COVID SYMPTOM-FREE (check box)							

PERSONAL CARE	**S**	**M**	**T**	**W**	**TH**	**F**	**S**
BATH							
Complete							
Partial							
Shower							
Tub							
PERINEAL CARE							
Assist to bathroom							
Assist to Commode							
Assist Catheter Care							
SKIN CARE							
Back Care							
Lotion							
Massage							
FOOT CARE							
Lotion							
Soaks							
Elastic Hose							
NAIL CARE							
Soak, Clean, File							
SHAVE							
ORAL CARE							
Teeth							
Dentures							
HAIR CARE							
Shampoo							
Comb, Brush							
DRESS							
Assist							
Self							
TRANSFERS							
Bed to W/C							
W/C to Bed							
Reposition							
R.O.M.							
INCONT. CARE							
TEMPERATURE							
PULSE							
WEIGHT							
BLOOD PRESS.							

HOMEMAKING	**S**	**M**	**T**	**W**	**TH**	**F**	**S**
Laundry/wash/fold							
Shopping/Errands							
CLEANING							
Kitchen							
Bathroom							
Bedroom/linens							
Living Room							
Trash removed							
NUTRITION							
Prepare Meal							
Enc. Fluids							
Enc. Food							
DIET RESTRICT.							
Low Sodium							
Diabetic							
FEEDING							
Feed Patient							
Assist Patient							
Med Cue Patient							
COMPANION							
SOCIALIZATION							
SAFETY							

Total Number of Hours_____

Patient Daily Signature:

Sun_____

Mon_____

Tues_____

Wed_____

Thu_____

Fri_____

Sat_____

Employee Signature:_____

Summit Weekly Visit Timesheet

Pay Period _____ to _____

Employee's Name *(Last, First):* _____

Patient's Name *(Last, First):*_____

Patient's Address: _____

Please check all appropriate boxes for care given on each day of service – put R in on appropriate box if patient refuses care on any day of service. Employee MUST FOLLOW CARE PLAN EXACTLY AS WRITTEN.

	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
Time In							
Time Out							
HHA							
Companion							
Home- maker							
Personal Care							
TOTAL HOURS							
COVID SYMPTOM-FREE (check box)							

PERSONAL CARE	S	M	T	W	TH	F	S
BATH							
Complete							
Partial							
Shower							
Tub							
PERINEAL CARE							
Assist to bathroom							
Assist to Commode							
Assist Catheter Care							
SKIN CARE							
Back Care							
Lotion							
Massage							
FOOT CARE							
Lotion							
Soaks							
Elastic Hose							
NAIL CARE							
Soak, Clean, File							
SHAVE							
ORAL CARE							
Teeth							
Dentures							
HAIR CARE							
Shampoo							
Comb, Brush							
DRESS							
Assist							
Self							
TRANSFERS							
Bed to W/C							
W/C to Bed							
Reposition							
R.O.M.							
INCONT. CARE							
TEMPERATURE							
PULSE							
WEIGHT							
BLOOD PRESS.							

HOMEMAKING	S	M	T	W	TH	F	S
Laundry/wash/fold							
Shopping/Errands							
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Kitchen							
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DIET RESTRICT.							
Low Sodium							
Diabetic							
FEEDING							
Feed Patient							
Assist Patient							
Med Cue Patient							
COMPANION							
SOCIALIZATION							
SAFETY							

Total Number of Hours_____

Patient Daily Signature:

Sun_____

Mon_____

Tues_____

Wed_____

Thu_____

Fri_____

Sat_____

Employee Signature:_____