Affordable Home Care LLC Timesheet

FAX 1888 681 9011 OR EMAIL office@IN-hhc.com. THIS FORM MUST BE FAXED OR EMAIL IN BY THE END OF THE DAY ON THE **1st and 16th** Please note: Your paycheck will be delayed if your time sheet is not received by the above dates.

PCA/CNA/HHA NAME		**Pay Period ended:**	15th or 30th/31st
PCA/CNA/HHA SIGNATURE:	In signing I am certifying that I have personally completed this timesheet and the hours are accurate.		
PATIENT NAME:	Signature		Date

Day - Date	Type	Start Time	End Time	Total Hrs.	Odometer Started	Odometer Ended	Total Mileage	Patient's Initial
			TOTALS					

Only one patient per the timesheet

Day - Date	Type	Start Time	End Time	Total Hrs.	Odometer Started	Odometer Ended	Total Mileage	Patient's Initial
Totals Hours/Mileage								

Condition Note:

AHC VISITING NOTE

PATIENT NAME: ____________________ EMPLOYEE NAME:____________________ BRANCH____________________

OFFICE USE ONLY

DAY	MARE	ATTN	HKM	PA	CHOICE	PVT	INSU	RES	VA	SSBG	T3	T3E	VHSP
MON													
TUES													
WED													
THUR													
FRI													
SAT													
SUN													

DAY	DATE	TIME IN	TIME OUT	TOTAL HOURS	TYPE1	TYPE2	TYPE3	PT INITIAL	STAFF INITIAL
MON									
TUES									
WED									
THUR									
FRI									
SAT									
SUN									

TYPES: ATTN/HMK/CHOICE/PA/RES/MEDICARE/T3/T3E/SSBG/CHSP/INSUR

WEEKLY HOURS: ______________

DESCRIPTION	M	T	W	TH	F	SA	SU	DESCRIPTION	M	T	W	TH	F	SA	SU
TUB/SHOWER ASSIST								REPOSITION BED/CHAIR PATIENT							
BATHROOM CLEAN UP								MEDICATION REMINDERS							
PERINEAL CARE								ASSIST TO BR, BSC, BED PAN							
SKIN CARE/LOTION								CATH CARE, FOLEY/EXT							
ORAL CARE/SHAVE								INCONTINENT CARE							
SHAMPOO/COMB								PREP OF MEALS/SNACKS							
SAFETY PROCAUTIONS								ERRANDS							
NAILS CLEAN/FILE								KITCEN CLEAN UP							
DRESS/UNDRESS								BED MADE/ LINEN CHANGE							
ASSIST WITH AMBULATION								CLIENT LAUNDRY DONE							
RANGE OF MOTION								MAINT. CLEAN EQUIP							
TRANSFER ASSIST								VACCUM/DUSTING							
			A		&		D		O	N	L	Y			
MECHANICAL LIFT								OSTOMY CARE							
OTHER								RECORD INTAKE/OUTPUT							
ASSIST FEEDING								CHECK/ REINFORCE DRESSING							

EMPLOYEE SIGNATURE: ____________________DATE ____________

PATIENTSIGNATURE____________________DATE______________