Sahal Home Care INC

Time and Activity Documentation Personal Support, Respite, Companion

Week 1	THU	FRI	SAT	SUN	MON	TUE	WED	Week 2	THU	FRI	SAT	SUN	MON	TUE	WED
Month/Day/Year								**Monthly/day/year**							
Time In Am/Pm								**Time In**							
Time Out Am/Pm								**Time Out**							
Total Daily Hrs:								Total Daily Hrs:							
Supports								**Supports**							
Dressing								Dressing							
Grooming								Grooming							
Bathing								Bathing							
Eating								Eating							
Transfers								Transfers							
Mobility								Mobility							
Positioning								Positioning							
Toileting								Toileting							
Health-Related								Health-Related							
Behavior								Behavior							
Other outings								Other outings							

Acknowledgement and Required Signatures: After the Caregiver documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from and the Review the completed timesheet for accuracy before signing. It is a federal crime to provide false information on Caregivers 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 Caregiver care plan.

Note: All times (Dates/Times) of client stay in Hospital, Care Facility, or Incarceration are **NOT** counted as caregiver service hours, and therefore are **NOT** billable.

Print Name:	Provider	**Please use standard 12 hr time and indicate AM and PM.**
Signature:	Date:	
Print Client Name:	MA # or DOB:	**OFFICE USE ONLY**
Client or Responsible Party Signature:	Date:	**Two Week Total:**

Caregiver Phone number: _____. Is there change of address of Caregiver or Client address? _____ . If yes, please update address below.