



TIMESHEET FOR HHA, RESPITE CARE AND LIVING IN ONLY

(1-877-674-8777). (Fax): 888-201-667 www.CareAtHome247.com

51 Union St, Suite 105, Worcester, MA 01608

Please use different time sheet for each patient.

Name of Care Giver	Client's Name:
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Select: Block A for sleep in 12 hrs shift, Block B for sleep in 16 hrs shift, Block C for sleep in 24 hrs shift.

Date	Days of Week	Block A: 8 HRS shift	Block B: 12 HRS shift	Block C: 16 HRS shift	Block D: 24 HRS shift	Sleep In	Miles or Hrs	Client Initial
	Sunday							
	Monday							
	Tuesday							
	Wednesday							
	Thursday							
	Friday							
	Saturday							

Total # of Block A:	Total # of Block B:	Total # of Block C:	Total # of Block D:	Total # of Hours:
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For each shift, please check which items you worked on with the client. The items checked should reflect care plan

Personal Care								Home Management							
Duties	S	M	T	W	T	F	Sat	Duties	S	M	T	W	T	F	Sat
Dressed/ Un								House Keeping							
Bed Bath								Changed Linens							
Oral Hygiene								Vacuumed							
Shampoo								Clean Bathroom							
Eating								Clean Kitchen							
Urinary								Grocery Shopping							
Meal Preparation								Dusted							
Med Reminders								Mopped Floors							
Take out Garbage								Made Bed							
Toileting								Transfer							
Bathroom								From the Chair							
Urinal								From the bed							
Attend Brief								In/ Out of Car							
								Hoyer Lift							
Activities								Activities							
Escort to Appt.								Errands							
Pet Care								Recreational							
Mail letters/ Bills								Transportation							

Additional Comments/ or Notes About the Patient.

EMPLOYEE AGREEMENT: I agree not to accept employment with the Client for the term of employment with Medical Staffing Group, Inc and for the 180 days after the termination of my employment with Medical Staffing Group, Inc. I declare that I have sustained no injury on this assigned job. By signing this time sheet, I certify that all services have been provided in accordance with the Client's CARE assessment and I have delivered all service hours shown on the time sheet. In order to be paid I understand this time sheet must be completed and signed by both me and the client. I understand I must indicate my availability below for further assignment prior to submitting this timesheet. This information is necessary for our records and also informs us of your availability for future assignments. Failure to do so results in our assumption of your voluntary termination from Medical Staffing Group and may impact your eligibility for unemployment. **All completed timesheet must be return to the office by Monday 12 PM.**

Monday <input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7	Tuesday <input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7	Wednesday <input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7	Thursday <input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7	Friday <input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7	Saturday <input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7	Monday <input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7
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_____ Employee's Signature

_____ Date