

St. Mary's Home Care Services, Inc.
TIMESHEET FOR WEEK BEGINNING _____ / ENDING _____

Client's Name: _____

Client's #: _____

Day of Week	Mo	Tu	We	Th	Fr	Sa	Su		
Enter Month/Date →									
Year: 2010									
Time You Arrived →									
Time You Left →									
Total Time Approved Each Day per POC (RN)								Total Hours Worked	Total Hours Paid
# of Hours You Worked →									
Aide's Initials →								# Of Days Worked	
Client's Initials →									

My signature certifies that I received services on the dates and times stated above. I understand that I should withhold my initials for days/times I do not receive service.
Client's Signature : X **Date:** _____

Assist with ambulation (walking)								Prepare meal(s): Breakfast/Lunch/Dinner						
Assist with transfer/mobility/turning								Serve meal/ Set up						
Supervise walking								Take out trash						
Supervise eating								Clean kitchen						
Feed client/Tube feed								Wash dishes and tidy after meal						
Chop-Grind-Puree-Thicken								Tidy after bath						
Shower/Full Bath								Clean bathroom						
Partial/Sponge Bath								Make bed						
Foot care (Soak/lotion)								Keep free of clutter						
Shampoo hair								Tidy						
Skin care (lotion)								Dust						
Retrieve clothes								Sweep						
Put clothes on/remove clothes								Mop						
Put on/remove therapeutic stockings								Vacuum						
Put on/remove prosthesis								Laundry						
Assist with buttons and zippers								Change linens on bed						
Put on/remove stockings/socks & shoes								Check smoke alarm						
Assist with Bladder: normal/ostomy/condom catheter/indwelling catheter														
Assist with Bowel: normal/ostomy								Assist with reading and writing						
Clean perineum														
Changing (Diaper/Brief/Pads)														
Toileting program														
Personal Hygiene														
Hair (Brush/Comb)														
Braid/Set Hair														
Wash/Dry face and hands														
Brush teeth/dentures														
Shave														
Medical Monitoring														
Medication Reminder (Remind only, do not give to client)														
Verify Blood Sugar (BS), Record on BS form and CHECK THIS BOX														
OTHER:														
								Aide's comments:						

My signature certifies that I performed the services listed and that the times and services are accurate. I understand that any false claims, statements, documents or concealment may be prosecuted under applicable Federal and/or State laws.

Aide's Signature: _____

Date: _____