2740 American Boulevard West, Suite 100, Bloomington, MN 55431
TEL: (952) 858-8827 FAX: (952) 540-4672

EMPLOYEE WEEKLY TIME SHEET

Employee Name: JANE SMITH Client Name: JOHN SMITH

DAY	DATE WORKED	TIME IN	TIME OUT	# OF HOURS	CLIENT SIGNATURE
Saturday	7/14/12				
Sunday	7/15/12				
Monday	7/16/12	8:00A	10:00A	2	John Smith
Tuesday	7/17/12				
Wednesday	7/18/12	8:00A	10:00A	2	John Smith
Thursday	7/19/12				
Friday	7/20/12	8:00A	10:00A	2	John Smith
Total Hours				6	

Employee Agreement: I certify that I have worked the hours listed on this timesheet.
I understand that my paycheck will be delayed if this time sheet and/or paperwork are incomplete.

Jane Smith
Employee Signature

7/20, 20 12
Date

Client's signature certifies that the hours of service noted above have been received.
Overtime & overlapping shifts must be pre-approved. Late Fee charge applies to all time sheets turned in two weeks late.

Professional Resource Network Home Health Care
Division of Professional Resource Network, Inc.

Professional Resource Network, Inc.

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Home Health Aide Time and Activity Documentation

Dates of service	7/14/12 MM/DD/YY (Saturday)	7/15/12 MM/DD/YY (Sunday)	7/16/12 MM/DD/YY (Monday)	7/17/12 MM/DD/YY (Tuesday)	7/18/12 MM/DD/YY (Wednesday)	7/19/12 MM/DD/YY (Thursday)	7/20/12 MM/DD/YY (Friday)

Activities

Dressing			✓		✓		✓
Grooming			✓		✓		✓
Bathing			✓		✓		✓
Eating			✓		✓		✓
Transfers			✓		✓		✓
Mobility							
Positioning							
Toileting			✓		✓		✓
Health Related							
Other							

Visit One

Ratio staff to recipient	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	1:1 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3
Shared care location							
Time In (Circle AM / PM)	AM PM	AM PM	8:00 (AM) PM	AM PM	8:00 (AM) PM	AM PM	8:00 (AM) PM
Time Out (Circle AM / PM)	AM PM	AM PM	10:00 (AM) PM	AM PM	10:00 (AM) PM	AM PM	10:00 (AM) PM

Visit Two

Ratio staff to recipient	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	1:1 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3
Shared care location							
Time In (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Visit Three

Ratio staff to recipient	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	1:1 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3
Shared care location							
Time In (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
DAILY TOTAL (Minutes)	Minutes	Minutes	120 Minutes	Minutes	120 Minutes	Minutes	120 Minutes

Total Minutes This Timesheet	**Total 1:1**	**Total 1:2**	**Total 1:3**
	360		

Acknowledgement and Required Signatures

After the HHA has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the HHA. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on HHA billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were preformed as specified in the HHA Care Plan.

RECIPIENT NAME (FIRST, MI LAST)	MA MEMBER # OR BIRTH DATE	HHA NAME (FIRST, MI, LAST)	HHA PROVIDER #
JOHN A. SMITH	12/3/45	JANE A. SMITH	678910

RECIPIENT/ RESPONSIBLE PARTY SIGNATURE	DATE	HHA SIGNATURE	DATE
John Smith	7/20/12	Jane Smith	7/20/12

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PROGRESS NOTES

CLIENT NAME: JOHN SMITH

EMPLOYEE NAME: JANE SMITH

DATE	TIME	NOTES SHOULD BE SIGNED BY CARE GIVER
7/16/12	10:00A	John was bathed and dressed then had breakfast.
7/18/12	10:00A	John was bathed and dressed then had breakfast.
7/20/12	10:00A	John was bathed and dressed then had breakfast.