Weekly Time Sheet

Weekending Date: ___/___/______
(ALWAYS SUNDAY)

EMPLOYEE NAME: ____

CONSUMER NAME: ____

CONSUMER ADDRESS: ____________________________________

	MONTH OF:	MON	TUES	WED	THURS	FRI	SAT	SUN
DATE:								
SHIFT ONE	Time in:							
	Time Out:							
SHIFT TWO	Time in:							
	Time Out:							
SHIFT THREE	Time in:							
	Time Out:							
	TOTAL:							

WEEKLY TOTAL HOURS: __________

COVID Q1. Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No
COVID Q2. Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No
COVID Q3. Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No
COVID Q4. Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No
If "YES", you will need to contact the office.

CONSUMER NOTE: By your signature, you certify that the hours shown are true and accurate, and work was completed satisfactorily for the days and times documented.

CONSUMER SIGNATURE: ____

EMPLOYEE NOTE: By your signature, you certify that the hours recorded for the above dates are true and accurate and are properly verified by the client.

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EMPLOYEE SIGNATURE **DATE**

***Timesheets are due by 12 p.m. Tuesday. Please drop off, or email to INFO@HANDSOFCHOICEHEALTHCARE.COM If timesheets arrives after deadline you will not be paid until the following week. EVV Telephone Number 1-844-994-3020**

COVID Q1. To your knowledge, in the past two weeks have you had close contact with someone currently diagnosed with Covid-19?
COVID Q2. Have you had any fever, chills, cough, difficulty breathing, sore throat, muscle aches, diarrhea, severe fatigue, nasal congestion, loss of sense of taste/smell the last 24 hours? COVID Q3. To your knowledge, in the past two weeks, has the consumer had close contact with someone currently diagnosed with Covid-19? COVID Q4. Has the consumer had any fever, chills, cough, difficulty breathing, sore throat, muscle aches, diarrhea, severe fatigue, nasal congestion, loss of sense of taste/smell in the last 24 hours?

Scope of Service Record

Directions: This is considered a legal document. Please check the care plan. Check each activity that is completed. Indicate "R" if an assigned activity was refused by the consumer. Indicate "H" for hospitalizations. **Reminder all consumer changes including hospitalizations should be called into the office IMMEDIATELY, (215)999-8500.**

ACTIVITY/DAY	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Meal Prep Circle **B L D SNACK**							
Feeding							
Incontinency Care							
Sponge Bath							
Shower Bath							
Mouth Care							
Hair Care							
Dressing							
Shaving							
Toileting							
Assist with walking							
Help with Walker							
Help with wheelchair							
Transfers w/o hoyer							
Hoyer Lift Transfer							
Escort							
Maintain Commode							
Living Room Vac/Dust							
Dining Room Vac/Dust							
Bedroom Vac/Dust							
Dishes and Cleanup							
Kitchen Floor/APPL							
Bed Change							
Laundry							
Bathroom							
Errands							
Trash Removal							