Private Home Care **TIME SHEET**- ***SUPPORTING DOCUMENTATION***

Client Name (Please Print)		**Week End Date:**	
Caregiver Name: (Please Print)		**Needs Type(s):**	

Private Home Care: For each shift, please check which items you worked on with the client. The items checked should reflect the goals in the Care Plan.

Remind/Observe/Support client with:	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**
Bathing							
Change Linens							
Conversation/Companionship							
Dressing							
Entertainment and appointment management							
Escort to appointments							
Feeding							
Games/Cards/Crafts							
Grocery Shopping							
Grooming							
Incontinence Care							
Laundry							
Light House Keeping							
Mail letters/Bills							
Make Bed							
Meal Plan/Prep							
Medication reminders							
Pet Care							
Recreational Activities							
Take out Garbage							
Transfers/Toileting							
Transport							

Date	Note

IMPORTANT - A COMPLETED TIMESHEET INCLUDES BOTH PAGE 1 AND 2 FILLED OUT IN ENTIRETY WITH AN AUTHORIZED SIGNATURE!

Caregiver Signature:______________________________________

ExpertCare Management Services as your employer is the only party that can authorize a change in your employee work schedule. Violation of this policy will result in disciplinary action up to or including termination.

ExpertCare Private Home Care Timesheet - *TIME IN/TIME OUT*

For Week Ending ____________ **Client Name:____________________**

Caregiver: Please fill in completely. Keep a copy for yourself. The ExpertCare copy of the time card must be received in our office by 8:00am on Monday, regardless of a holiday. Failure to turn in your timesheet by the deadline will result in delay of pay until the next pay date. ExpertCare Management Services, 210 Town Center Drive, Troy, MI 48084, Fax (248) 740-3505

Employee Name:	Hours Worked	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Total Hours
	Date								
Standard Care • Companionship • Meals • Errands • Support Services • Housekeeping	Time In								
	Time Out								
	Total Hours								
Personal Care (as indicated in Care Plan) • Bathing / Showering • Incontinence Care	Time In								
	Time Out								
	Total Hours								
Transportation for Errands • MUST have authorization for this service • Reimbursement only if driving caregiver vehicle	Miles: To								
	Miles: From								
	Total Miles:								

- ***Please indicate the hours worked under the type of Needs***

I attest, under the penalty of perjury, I have worked the hours declared above and they are true, correct. Signatures are not to be copied from a previous timesheet and must be the original signatures. Clients, by signing this timesheet you attest that all information is accurate. No whiteout or pre-signed timesheets will be accepted.

Caregiver's Signature:____

Last 4 digits of social security number:___________

X____ ___________

Authorized Client Signature **Date**