Faith Care and Companion Services LLC.
99 East Center Street, Manchester, CT, 06040
860-643-1300

Client Care Record / Home Health Aide Timesheets

CLIENT NAME (First, MI, Last)	HOME HEALTH AIDE (First, MI, Last)

For the week of: _____/_____/_____ thru _____/_____/_____
MM DD YY MM DD YY

DATES OF SERVICE (MM/DD)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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 HOURS							
						TOTAL HOURS FOR WEEK	

Instruction: Cares performed must be documented by staff initials. R = Refused (document below)

		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
BATH	Bath/Shower							
	Sponge Bath/Bed Bath							
	Shampoo							
	Shave							
	Oral Care/Denture Care							
	Dressing							
BLADDER / BOWEL	Catheter Care							
	Toilet/Commode							
	Bedpan/Urinal							
	Brief/Pad							
	Incontinent							
	Peri Care							
AMBULATION	Distance							
	Frequency							
	Assist with Transfers							
	Use Transfer Belt							
	Bedbound							
	Weight Bearing: Full/Partial							
	Cane/Crutches							
	Walker/Wheelchair							
RANGE OF MOTION	PROM U L							
	AROM U L							
	Apply Limb Prosthesis							
	Braces							
	TEDS/Ace Wraps							
SKIN / SENSORY	Lotion to Skin							
	Nail Care							
	Turn & Position							
	Foot Soak							
	Non Sterile Drsg Chg							
	Glasses/Contacts							
	Hearing Aide: L R							
MEALS	Restrict Fluids/Push Fluids							
	Feed Client							
	Meal Prep: B L D SN							
	Supplement Given							
	Weight							
HOUSEHOLD SERVICES	Vacuum							
	Laundry							
	Kitchen/Dishes							
	Bathroom(s)							
	Empty Garbage							
	Make Bed, Change Linen							
OTHER								
Client Initals:		X	X	X	X	X	X	X

CLIENT SIGNATURE	DATE	Administration Review	DATE

NOTE: ALL TIMESHEETS MUST BE RECEIVED EVERY MONDAY BY **5:00 pm** FOLLOWING THE WEEK WORKED. PLEASE CALL AFTER YOU SEND YOUR TIMESHEETS TO MAKE SURE THEY WERE RECEIVED.

Office Use Only: Please Initial & Date

ADMIN	HHA SUP	RN SUP