



Maplewood Home Care

seniorhomeinc.com

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Homemaker Time and Activity Documentation

Recipient Name	MA #	DOB
Homemaker Name	Provider #	

Dates / Times / Location of Recipient's stay in: Hospital, Care Facility, Incarceration

Dates of Service mm/dd/yyyy	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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CLEANING

Vacuum, Sweep, Mop							
Dust							
Make Bed							
Clean Kitchen							
Clean Bathroom							
Take out Trash							
Laundry							
Ironing							
Defrost/Clean Refrigerator							
Wash Dishes							

NURTRITION

Plan, Prepare Meal							
Purchase Food							

Miscellaneous							
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Ratio staff to recipient	1:1	1:1	1:1	1:1	1:1	1:1	1:1
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							
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Weekly Total Minutes This Time Sheet	
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Acknowledgement and Required Signatures

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

Recipient / Responsible Party Signature	DATE
Homemaker Signature	DATE