



LIVING HANDS

Home Health Care Agency

Tax ID #46-4100916

Telephone: (267)441-3537, Fax(484)472-7056

TIMESHEET MISSED CLOCK-IN/OUT

CAREGIVER NAME: _____

CAREGIVER SSN: XXX-XX- ____ _

CLIENT NAME: _____

CLIENT ADDRESS: _____

CLIENT MEDICAID: _____

WEEK ENDING DATE*: _____

MCO: _____

*Each pay week ends on SATURDAY.

DUTY CODE/SERVICES PROVIDED

(Check ALL that apply)

Meal Preparation (002)	115	Housework	116	Managing Finances	117
Managing Medications	118	Shopping	119	Transportation	120
Hygiene	122	Dressing Upper	123	Dressing Lower	124
Locomotion	125	Transfer	126	Toilet Use	127
Bed Mobility	128	Eating	129	Bladder Incontinence	130
Bowel Incontinence	131	Personal Care-T1019	132	Bathing	134
Bathing	135	Lotion/Ointment	137	Laundry (246)	138
Reading/Writing	139	Supervision/Coaching	140	Incontinence Care	141
Catheter Care	142	Wound Care	143	G-tube Feeding	144
In Person (SCE)	201	Via Telephone (SCE)	202	Other (SCE)	203

DATE OF SERVICE (Calendar Date)	DAY (Day of the week)	START TIME	END TIME	TOTAL HOURS	LOCATION OF SERVICES
					Home
					Home
					Home

CLIENT Signature: _____ Date: _____

("Client Signature", by signing above, you hereby agree and acknowledge receipt of rendered services)

CAREGIVER Signature: _____ Date: _____

("Caregiver Signature", by signing above, I hereby state that the timesheet reflects accurate representation of hours worked)

AGENCY Signature: _____ Title: _____ Date: _____

"The Agency you will grow to LUV. We provide the service you deserve!"