LUVING 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: _____**

**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** |

**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:** _____

**Each pay week ends on **SATURDAY**.*

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

*Last Revised 5/01/2025*