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:** _____ **CLIENT NAME:** _____

**CAREGIVER SSN: XXX-XX** __ __ __ __ **CLIENT ADDRESS:** _____

**WEEK ENDING DATE *:** _____ **CLIENT MEDICAID:** _____

**Each pay period ends on SATURDAY.* **MCO:** _____

**DUTY CODE/SERVICES PROVIDED** *(Check ALL that apply)*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Meal Preparation **(002)** | **115** | | Dressing Lower | **124** | | Personal Care – T1019 | **132** | |
| Housework | **116** | | Locomotion | **125** | | Bathing | **134** | |
| Managing Finances | **117** | | Transfer | **126** | | Lotion/Ointment | **137** | |
| Managing Medications | **118** | | Toilet Use | **127** | | Laundry **(246)** | **138** | |
| Shopping | **119** | | Bed Mobility | **128** | | Reading/Writing | **139** | |
| Transportation | **120** | | Eating | **129** | | Incontinence Care | **141** | |
| Hygiene | **122** | | Bladder Incontinence | **130** | | | | |
| Dressing Upper | **123** | | Bowel Incontinence | **131** | | | | |

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

**CERTIFICATION**

I certify that the hours recorded on this timesheet are true, accurate and complete. I further certify that I personally performed all work hours reported that the services were provided as documented, and that I have not falsified or misrepresented any information contained on this timesheet. I understand that submitting false or inaccurate information may result in disciplinary action, up to and including termination of employment, and may subject me to civil and/or criminal penalties under applicable federal and state laws.

_____ CLIENT'S INITIALS

_____ CAREGIVER'S INITIALS

**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!"*

*Revised 8.5.2026*