



Brighthaven
Homecare

Fax timesheets to: 954-248-3871

Email: brighthavenhomecare@gmail.com

Client Name: _____ Contractor Name: _____

Day	Date	Time In ***REQUIRED**	Time Out ***REQUIRED***	Time In	Time Out	Total Hours ***REQUIRED***	Client Initials Verified ***REQUIRED***
SUN							
MON							
TUE							
WED							
THU							
FRI							
SAT							
Total Number of Hours worked this week							

REQUIRED

Check appropriate boxes as to care provided

DAY | SUN | MON | TUE | WED | THU | FRI | SAT |

Personal Care Provided

Bathing Assistance							
Dressing Assistance							
Oral Hygiene							
Toileting Assistance							
Transfer Assistance							
Ambulation							
Range of Motion (ROM)							

Homemaker Services

Housekeeping/Cleaning							
Make Bed							
Wash Dishes							
Laundry							
Sweeping							
Dusting							
Mopping							
Light Vacuuming							
Empty Trash							

Respite Care

Light Housekeeping							
Personal Care							
Errands							
Meal Preparation							
Emotional Support							

Companion

Escort to Appointments							
Accompany on Walk							
Monitor of AOL's							
Medication Reminder							

Vital Signs / Blood Pressure

Notes: _____

Both employee and Care Recipient/Client ("Care Recipient") acknowledge Brighthaven Homecare is the referral source for this assignment and is entitled to be compensated for said referral. It is agreed Care Recipient shall not employ, for any purpose, either directly or indirectly, the employee or contractor during the assignment and for a period of 1 year following termination of the assignment without compensating Brighthaven Homecare for its referral. In the event the employee/contractor and Care Recipient violate this provision, they shall be liable for liquidated damages to Brighthaven Homecare in the amount of \$15,000.00 each, in addition to all legal costs, including reasonable attorney's fees. The employee and Care Recipient agree this sum is not a penalty, but rather adequately represents the damages sustained by brighthaven caused by the breach of this provision.

Care Recipient agrees to pay all invoices upon receipt and agrees to pay interest on any unpaid balance over 30 days at a rate of 1.5% per month (annual rate of 18%) in addition to collection costs, if any, including reasonable attorney's fees.

By signing below, the employee and Care Recipient certify the hours, date(s), and nature of services indicated are correct and the services were performed in a satisfactory manner.

Assignment of benefit (if applicable):

I hereby authorize my insurance company to pay Brighthaven Homecare directly for the services provided to me.

_____/_____/_____

Care Recipient Signature

Date

I, the employee, certify that the hours, dates, and services reflected in this timesheet are accurate, and the services I provided were authorized by the Care Recipient and Brighthaven. I certify that I did not receive any injuries during this period while providing services to the Care Recipient.

I, the employee, have not gotten paid directly from the Care Recipient, nor have I agreed to work directly for the Care Recipient without the prior written consent of Brighthaven Homecare. I understand and acknowledge that doing so is a material breach of my employee Agreement.

_____/_____/_____

Employee Signature

Date