2 Helping Hands SERVICES LLC

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BI-WEEKLY TIMESHEET

CLIENT NAME (First, MI, Last)	EMPLOYEE NAME (First, MI, Last)
Period Starting Date: MM / DD / YYYY	Period Ending Date: MM / DD / YYYY

WEEK 1	DATES OF SERVICE (MM/DD)	Sunday ___/___	Monday ___/___	Tuesday ___/___	Wednesday ___/___	Thursday ___/___	Friday ___/___	Saturday ___/___
	TIME IN							
	TIME OUT							
	TOTAL HOURS							

TOTAL HOURS FOR 1st WEEK

WEEK 2	DATES OF SERVICE (MM/DD)	Sunday ___/___	Monday ___/___	Tuesday ___/___	Wednesday ___/___	Thursday ___/___	Friday ___/___	Saturday ___/___
	TIME IN							
	TIME OUT							
	TOTAL HOURS							

TOTAL HOURS FOR 2nd WEEK

TOTAL HOURS

AIDE DAILY ACTIVITY LOG

ACTIVITIES	Week 1 S	M	T	W	TH	F	S	Week 2 S	M	T	W	TH	F	S
Bathing														
Hair Care														
Dressing														
Lotion/Ointment/Oil														
Meal preparation														
Eating/ Drinking														
Laundry														
Light Housekeeping														
Shopping														
Medication Reminder														
Reading / Writing														
Managing Finances														
Social / Leisure Activities														
Safety Environment														
Securing Transportation														
Appointment Scheduling														
Taking out the trash														
Make up bed														
Assist Prosthetic Device														
Ambulating														
Range of Motion														
Supervised Walks														
Supervision/Coaching/ Cueing														
Toileting														
Bowel / Bladder Mgmt.														
Transfers														
Incontinence														
Assist Catheter Care														
Assist Wound/ Skin														
G-Tube Feeding														
Other														

Initial at the end of the shift

Week 1	CLIENT	Employee
Sun		
Mon		
Tue		
Wed		
Thur		
Fri		
Sat		
Week 2		
Sun		
Mon		
Tue		
Wed		
Thur		
Fri		
Sat		

Note:

Notice: By signature below by both Client and Employee, you certify that the hours are accurate, and that care was Provided on the dates mentioned above. You also agreed to reimburse the amount if you have provided false record on this timesheet.

CLIENT SIGNATURE	DATE	EMPLOYEE SIGNATURE	DATE

Supervisor

Continuing notes on the back

CNA/PCA Notes
Please Mark Services Provided:

Bath (Per Request)

- Bed
- Shower
- Tub Other: _____

Oral Care (Per Request)

- Dentures Cleaned
- Teeth Brushed
- Gums, teeth & tongue swabbed
- Moisturized applied to lips
- Other _____

Skin Care (Per Request)

- Lotion/Oil applied to skin.
- Back Rub
- Turn & Preposition

Grooming (Per Request)

- Assist patient w/dressing
- Nail Care
- Hair Combed/brushed
- Other: _____

Nutrition (Per Request)

- Assist w/feeding
- Food Prep.
- NPO

Safety Precautions:

- Seizure Precautions
- Use of Side Rails
- O2 Safety
- Other
- Fall Precautions/Environment Safety

Activities:

Transferred Patient To:
Bed
Wheelchair
Commode
Chair

Assisted Patient to Ambulate Using
Cane
Gait Belt
Walker

Elimination:
Disposable Briefs
Bedpan Urinal
BSC
Catheter External or Foley
Peri-Care_____
Ostomy Care_____
Empty drainage bag
BM: Yes or No How many times? _____

Housekeeping:
Bedroom Cleaning
Bathroom Cleaning
Kitchen Cleaned

Doctor Apt: _____
Hospitalizations: _____

Comments/Observation Reported to Nurse:

_____
_____
_____
_____
_____
_____
_____

CNA/PCA SIGNATURE: _____

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