IHSS Time Card

D=Declined X=Completed

Client Name :_____ Client Address : _____

Employee Name : _____

Week of ____/_____/_____ **Through**____/_____/_____

Select Class of Care = PCP/ HM /RPCP/ Respite

	Sun	Mon	Tues	Wed	Thrus	Fri	Sat
Date							
Time In							
Time Out							
Recorded EVV							
Time In							
Time Out							
Recorded EVV							
Personal Care	**Sun**	**Mon**	**Tues**	**Wed**	**Thrus**	**Fri**	**Sat**
Bathing							
Dressing							
Skin Care							
Transfers							
Mobility							
Eating							
Respiratory Assistance							
Postioning / Turning							
Bladder / Bowel Care							
Hygiene							
Medical Equipment							
Medication Reminder							
Protective Oversight							
Accompaniment							
Exercise							
Homemaker	**Sun**	**Mon**	**Tues**	**Wed**	**Thrus**	**Fri**	**Sat**
Floor Care							
Bathroom							
Kitchen							
Trash							
Meal Preparation							
Dishwashing							
Bed Making							
Laundry							
Shopping							
Dusting							
Heath Maintenance	**Sun**	**Mon**	**Tues**	**Wed**	**Thrus**	**Fri**	**Sat**
Bathing							
Dressing							
Skin Care							
Transfers							
Mobility							
Feeding							
Respiratory Care							
Postioning / Turning							
Bladder Care							
Bowel Care							
Hair Care							
Nail Care							
Mouth Care							
Medical Management							
Medication Assistant							
Exercise							
Accompaniment							

Provider Comments

Must Include Date & Time

Client Signature: _____ Date _____

Attendant Signature : _____ Date _____