



**Global Home Health  
Care Inc.**

**Homemaker Timesheet and  
Activity Documentation**

All time sheets must be turned into the office no later than 5:00pm on Monday  
Time sheets may be mailed to the office, but they must be postmarked by Monday.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Dates of Service:</b> (in consecutive order)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)
<b>Activities</b>							
<b>Cleaning</b>							
<b>Living Room:</b>	Dust						
	Vacuum						
<b>Kitchen:</b>	Wash Dishes						
	Clean Oven/Refrigerator						
	Empty Garbage						
	Sweep/Mop Floor						
<b>Bathroom:</b>	Clean Toilets/Bathtub						
	Sweep/Mop Floor						
	Clean Sinks						
	Empty Garbage						
<b>Bedroom:</b>	Change Bed Linens						
	Dust						
	Vacuum						
	Empty Garbage						
<b>Laundry:</b>	Load Washer/Dryer						
	Fold Clothes						
	Put Away Clothes						
<b>Home Management</b>							
<b>Shopping:</b>	Grocery Shopping						
	Clothing Shopping						
	Household Items Shopping						
<b>Transportation Arrangement:</b>							
<b>Meal Preparation:</b>							
<b>Errands:</b>							
<b>Assistance with ADL</b>							
<b>Activities:</b>	Ambulating						
	Bathing						
	Dressing						
	Eating						
	Grooming						
	Toileting						
<b>FIRST VISIT OF THE DAY (Visit One)</b>							
Time In (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
<b>SECOND VISIT OF THE DAY (Visit Two)</b>							
Time In (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Total Daily Hours							
<b>Total Hours on This Timesheet</b>							

**Relationship (I am related to the Recipient as:)**

Parent, Sibling, Adult Child, Grandparent or Grandchild (U1)
  None of the Above (UD)

**Acknowledgement and Required Signature**

After HM has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the PCA. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on HM billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the HM Care Plan.

<b>Recipient's Name (First, MI, Last)</b>	<b>MA Member # or D. O. B</b>	<b>Recipient/Responsible Party Signature</b>	<b>Date</b>
<b>Homemaker's Name (First, MI, Last)</b>	<b>Provider ID #</b>	<b>Homemaker's Signature</b>	<b>Date</b>