

Homemaker Timecard / Billing

Please use for direct time only, training time is documented on additional form

Please use one form per Recipient

****Please be sure to complete Daily Service Record on back****

Staff Name: _____

Recipient Name: _____

Recipient MHCP id #: _____

Recipient DOB: _____

Pay Period Dates / / to / /

		**Please circle AM or PM							
		Visit One		Visit Two		Visit Three		Total Hrs.	
DATE:		<i>In</i>	<i>Out</i>	<i>In</i>	<i>Out</i>	<i>In</i>	<i>Out</i>		
Week One	<i>Sunday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Monday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Tuesday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Wednesday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Thursday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Friday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Saturday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
Week Two	<i>Sunday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Monday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Tuesday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Wednesday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Thursday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Friday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
	<i>Saturday</i>	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		

****It is a federal crime to provide false information for Medical Assistance Payment****

Staff Signature

Recipient or Legal Guardian Signature

please draw a line through dates if services were not received

(signature required on back also)

HOMEMAKER DAILY SERVICE RECORD

Recipient Name: _____

Pay Period Dates: _____ to _____

*** Please initial corresponding box indicating the date individual tasks were addressed and indicate location of service (ie. Home or Community)

Location

Date:

Meal Preparation														
Shopping and Errands														
Routine Household Care														
Assist with Activities of Daily Living														
Transportation Arrangement														
Companionship														
Social Stimulation														
Safety and Well-Being Monitoring														

Comments/Concerns (i.e. changes in recipients condition, documentation of calls to supervisor): _____

Recipient or Legal Guardian

Staff Signature/Date: _____

Signature/Date: _____