Shaba Health Services Corp. **617 Cedar Ave S #A Mpls, MN 55454 P (612) 867 – 9699 F (612) 354 – 7152**

Homemaker Services Timesheet

Client Name: _____Employee Name: _____Pay End Date: _____

Day	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Total Hours
Date															
Time In	A P	A P	A P	A	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	
Time Out	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	
Daily Hrs.															

Recipient or Responsible Party: Please draw a line through any date or time that you did not receive services. Employee: Initial each task performed to the client in the below boxes A for AM and P for PM

Activities:	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
Light Housekeeping														
Grocery Shopping														
Empty Garbage														
Clean Stove/Counters														
Clean Refrigerator														
Clean Bathroom														
Change Bedding														
General Laundry														
Wash Dishes														
Meal Preparation														
Social Recreation														
Errands														
Other Tasks:														

Acknowledgement of Responsibility: The undersigned hereby acknowledge that it is a federal crime to provide or report false information on time sheets to be billed to Medical Assistance for payment. By signing below, the client and employee of acknowledge that all of the above information given is true and accurate.

_____ _____ _____

Client or Responsible Party Signature Employee Signature Date

** ** **Please mail after last shift is worked or Drop off by NOON - Tuesday following the end of pay period.**

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Shaba Health Services Corp will not provide Shared PCA Services.

PCA Services Timesheet

Client Name: _____Employee Name: _____End Date:_____

Day	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Total Hours
Date															
Time In	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	
Time Out	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	A P	
Daily Hrs.															

*****Employee please Initialize each task performed to the client in the below boxes** **A = AM or P = PM**

Activities:	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
Dressing:														
Grooming:														
Bathing:														
Eating:														
Transfers:														
Mobility:														
Positioning:														
Toileting:														
Cleaning:														
Laundry:														
Health Related:														
Behavior:														
Other Tasks:														

ACKNOWLEDGEMENT AND REQUIRED SIGNATURES: After the PCA has documented his/her time activity, the client must draw a line through any dates and times he/she did not receive services from the PCA. The client or the responsible party must review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on PCA 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 PCA CARE PLAN. Please write comments and view description of the activities on the back.

_____ _____ _____

Client or Responsible Party Signature Employee Signature Date

** ** **Please mail after last shift is worked or Drop off by NOON - Tuesday following the end of pay period.**