

Silver Mountain Home Health Care LLC

1607 Chicago Ave S, Minneapolis, MN 55404 Phone: 612-226-5375 Fax: 651-204-9193
 Email:Info@silvermountainhhc.com

RESpite IN HOME

Employee's Name: _____

Client's Name: _____

Client Representative Name: _____

<i>Date:</i>	<i>Time In</i>	<i>Time Out:</i>	<i>Date:</i>	<i>Time In:</i>	<i>Time Out:</i>
01/25/24	am/pm	am/pm	02/01/24	am/pm	am/pm
01/26/24	am/pm	am/pm	02/02/24	am/pm	am/pm
01/27/24	am/pm	am/pm	02/03/4	am/pm	am/pm
01/28/24	am/pm	am/pm	02/04/24	am/pm	am/pm
01/29/24	am/pm	am/pm	02/05/24	am/pm	am/pm
01/30/24	am/pm	am/pm	02/06/24		
01/31/24	am/pm	am/pm	02/07/24	am/pm	am/pm

Has the Client been in the Hospital, a Care Facility or Incarcerated during these two weeks?

If so, please complete the following: Date in _____ Date out _____

Acknowledgement and Required Signatures (not valid unless signed by both Parties):

Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on this timesheet. Your signature verifies the time and services entered above are accurate. *All time documented is assumed to be 1 staff to 1 client (1:1) unless otherwise noted above time entry for that shift. For example, staff working with 2 clients at once should indicate 1:2 above time entries, 1:3 etc. A separate timesheet should be done for each client with whom the staff works.

Employee Signature

Date

Client/Client Rep

Date