

**Silver mountain Home Health care LLC. 1607 Chicago Ave MN 55404 -612-226-5375 fax 651-204-9193**

**NIGHT SUPERVISION TIME SHEET**

**Client Name:** \_\_\_\_\_ **Employee Name:** \_\_\_\_\_ **File#** \_\_\_\_\_

**For the week of Thursday** \_\_\_\_\_ **Thru Wednesday:** \_\_\_\_\_

Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday
<b>Date:</b> 03/28/2024	<b>Date:</b> 03/29/2024	<b>Date:</b> 03/30/2024	<b>Date:</b> 03/31/2024	<b>Date:</b> 04/01/2024	<b>Date:</b> 04/02/2024	<b>Date:</b> 04/03/2024
<b>Time In:</b>	<b>Time In:</b>	<b>Time In:</b>	<b>Time In:</b>	<b>Time In:</b>	<b>Time In:</b>	<b>Time In:</b>
<b>Time Out:</b>	<b>Time Out:</b>	<b>Time Out:</b>	<b>Time Out:</b>	<b>Time Out:</b>	<b>Time Out:</b>	<b>Time Out:</b>
<i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i>  _____ Night Supervision  _____ Other	<i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i>  _____ Night Supervision  _____ Other	<i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i>  _____ Night Supervision  _____ Other	<i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i>  _____ Night Supervision  _____ Other	<i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i>  _____ Night Supervision  _____ Other	<i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i>  _____ Night Supervision  _____ Other	<i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i>  _____ Night Supervision  _____ Other
<b>Total Hours:</b>	<b>Total Hours:</b>	<b>Total Hours:</b>	<b>Total Hours:</b>	<b>Total Hours:</b>	<b>Total Hours:</b>	<b>Total Hours:</b>
<b>Client/Responsible Party and Staff MUST review the complete time sheet for accuracy before signing.</b> Your signature verifies the time and services entered above are accurate and that the client was not admitted to another facility during the times provided (i.e. hospital, ICF-MR or Respite facility).						<b>Total Hours for the Week:</b>
<b>EMPLOYEE SIGNATURE:</b>						<b>Date Signed:</b>
<b>CLIENT/RESPONSIBLE PARTY SIGNATURE (Please authorize all hours before signing here):</b>						<b>Date Signed:</b>

**NOTE: ALL TIMESHEETS MUST BE RECEIVED EVERY MONDAY BY 10:00 AM FOLLOWING THE WEEK WORKED. PLEASE CALL AFTER YOU SEND YOUR TIMESHEETS TO MAKE SURE THEY WERE RECEIVED.**