

**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:** \_\_\_\_\_

<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>
<b>Date:</b> 05/02/2024	<b>Date:</b> 05/03/2024	<b>Date:</b> 05/04/2024	<b>Date:</b> 05/05/2024	<b>Date:</b> 05/06/2024	<b>Date:</b> 05/07/2024	<b>Date:</b> 05/08/2024
<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.**