

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 Web: www.silvermountainhhc.com

INDV HOME SUPTS W/O TRNG

Employee's Name: _____

Client's Name: _____

Client Representative Name: _____

Date:	Time In	Time Out:		Date:	Time In:	Time Out:
07/11/2024	AM/PM	AM/PM		07/18/2024	AM/PM	AM/PM
07/12/2024	AM/PM	AM/PM		07/19/2024	AM/PM	AM/PM
07/13/2024	AM/PM	AM/PM		07/20/2024	AM/PM	AM/PM
07/14/2024	AM/PM	AM/PM		07/21/2024	AM/PM	AM/PM
07/15/2024	AM/PM	AM/PM		07/22/2024	AM/PM	AM/PM
07/16/2024	AM/PM	AM/PM		07/23/2024	AM/PM	AM/PM
07/17/2024	AM/PM	AM/PM		07/24/2024	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 _____			
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 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