Provident Care

All Time Sheets must be verified & Signed by Client or authorized individual.

Home Care - Record & Charge ***Please total amount of hours in each column.***

Employee (Last, First)			
___ Personal Attendant	___ Live-In	___Other: _____	**Client Signature & Verification** _____
Client: (Last, First)			I have received the services as indicated below

Start New Time Record For EACH Client every Sunday. Turn Time Records into office No Later Than 12:00 Noon every Monday or immediately after an assignment has ended. Office # (209) 578-1210 Fax # (209) 549-9364

Day	Date	Start Time	End Time	Reg.	Travel	Mileage	Comments
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Total Number of Hours Worked							

SERVICE PROGRESS NOTES

Chart if appropriate:	Sun	M	Tu	W	Th	F	Sa	**Chart if appropriate:**	Sun	M	Tu	W	Th	F	Sa
Complete Bath - Shower/Tub								Pt. sad or cheerful							
Complete Bed Bath								Pt. confused, disoriented,							
Partial Bath - Chair / Bed								Fluids Encouraged							
Mouth Care								Meal Preparation - Reg, Diet, Special							
Dentures Cleaned								Specify _____							
Hair Shampooed								Patient Fed							
Hair Combed								percent eaten - % B L D							
Shave								Self - Administered Meds (assist)							
Fingernails Cleaned								Floors - mop vacuum sweep (10 Mins. Max)							
Skin Massage								Cleaned Kitchen (10 Mins. Max)							
Special Skin Care								Wash & Dry Dishes (10 Mins. Max)							
Skin Care- Powder / Lotion								Pt Rm. Dusted – Tidied (10 Mins. Max)							
Toileting Assist								Clean Bathrooms x (10 Mins. Max)							
Incontinent Change x ____								Bed Made x (10 Mins. Max)							
Peri Care								Linen Change							
Catheter Care								Laundry - folded, put away (10 Mins. Max)							
Assist in Dressing – Partial								Shopping /Errands							
Range of Motion								Observe Patient							
Transfer Assist - bed to chair								Socialization							
Transfer Assist - chair to bed								Safety Precautions							
Assist to Ambulate								Side Rails Up							
with cane								Stand By / Prevent Falls							
with walker								Wheels Locked							
with crutches															
Exercise Assist as Prescribed															

CHANGE IN CONDITION / BEHAVIOR REPORTED TO OFFICE

Date	COMMENTS	Reported To:	Signature

I have read and understand Provident Care's Company Policies. By signing below, I agree that I have followed Provident Care's Company Policies.

EMPLOYEE SIGNATURE _____ **DATE** _____