Arise Cares
2907 Clearwater Rd Ste 200
St Cloud, MN 56301
(320) 230-6348

HCA Time and Activity Documentation

Start Date / / End Date / /

Review the completed timesheet for accuracy before signing. Your signature verifies the time and services entered are accurate and that the services were performed as specified in the Care Plan.

Incorrect time sheets will be returned for correction and not paid on time.

Time sheet MUST be filled out in BLACK or BLUE PEN and NO WHITEOUT OR PENCIL!

Shadowing Date:_____ **Total hours:**_____**(No more than 2 or as directed by your office coordinator; do not claim time below)**

Week One- Do not include shadowing

	Sun		Mon		Tues		Wed		Thurs		Fri		Sat	
Dates of Service	/		/		/		/		/		/		/	
If Shared care circle Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Time In	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P
Time Out	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P
Daily Total														
Vital Signs (circle) T P R B/P Wt.														
Bath (circle) bed / tub / shower / sponge														
Incontinent Care														
Dressing														
Grooming (circle) hair / oral care / dentures														
Skin Care														
Nail Care (circle) Toenails / Fngernails														
Elimination (circle) Toilet / Commode / Bed pan														
Catheter Care														
(circle) Med Remind / Assist														
(circle) Grocery Shopping Meal Plan / Meal Prep														
(circle) Assist Feed / Tube Feed														
Positioning														
Ambulation (circle) Walker / Cane / WC / Crutches														
Transfers (circle) Chair / Bed / Bath / Wheelchair														
Active/passive ROM Exercise Program														
Clean (circle) Bed / Bath / Kitchen														
(circle) Laundry / Ironing / Bedding														
Other														
Mileage														

Week Two- Do not include shadowing

	Sun		Mon		Tues		Wed		Thurs		Fri		Sat	
Dates of Service	/		/		/		/		/		/		/	
If Shared care circle Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Time In	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P
Time Out	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P	A / P
Daily Total														
Vital Signs (circle) T P R B/P Wt.														
Bath (circle) bed / tub / shower / sponge														
Incontinent Care														
Dressing														
Grooming (circle) hair / oral care / dentures														
Skin Care														
Nail Care (circle) Toenails / Fngernails														
Elimination (circle) Toilet / Commode / Bed pan														
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(circle) Med Remind / Assist														
(circle) Grocery Shopping Meal Plan / Meal Prep														
(circle) Assist Feed / Tube Feed														
Positioning														
Ambulation (circle) Walker / Cane / WC / Crutches														
Transfers (circle) Chair / Bed / Bath / Wheelchair														
Active/passive ROM Exercise Program														
Clean (circle) Bed / Bath / Kitchen														
(circle) Laundry / Ironing / Bedding														
Other														
Mileage														

Total time rounded to quarter hours (15 min = .25 etc) Do not includ shadowing

Total Week 1

Total Week 2

Timesheet Total 1:1

Timesheet total 1:2 Shared

Print_____**Sign** X _____ _____
Client Name **Client Name**

Print HCA Name _____ **Sign HCA Name**_____ _____