Intercommunity Home Health Care– 27 E Franklin Ave – Minneapolis, MN 55404.

Ph: 612-435-0283 Fax: 612-338-1493

PERSONAL SUPPORT/RESPITE – AHS

Client Name _____ **Employee Name** _____

For the week of: **Thursday** _____ thru **Wednesday** _____

Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday
Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Time In:	**Time In:**	**Time In:**	**Time In:**	**Time In:**	**Time In:**	**Time In:**
Time Out:	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**
Please indicate the program in which you worked for this day:	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*
_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support
_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion
____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision
_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily
Total Hours:	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**

Client/Responsible Party and Staff MUST review the complete timesheet for accuracy before signing. 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).

Total Hours for Week:

EMPLOYEE SIGNATURE:	**DATE SIGNED:**
CLIENT/RESPONSIBLE PARTY SIGNATURE (Please authorize all hours before signing here):	**DATE SIGNED:**

NOTE: ALL TIMESHEETS MUST BE RECEIVED EVERY THURSDAY BY 10:00 AM FOLLOWING THE WEEK WORKED. PLEASE CALL AFTER YOU SEND YOUR TIMESHEETS TO MAKE SURE THEY WERE RECEIVED. BLANK TIMESHEETS CAN BE FOUND AT OUR WEBSITE WWW.INTERCOMMUNITYHHC.ORG

REVISED NOV 2018

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Time In:	**Time In:**	**Time In:**	**Time In:**	**Time In:**	**Time In:**	**Time In:**
Time Out:	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**
Please indicate the program in which you worked for this day:	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*	*Please indicate the program in which you worked for this day:*
_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support	_____ Personal Support
_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion	_____ Adult Companion
____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision	____Night Supervision
_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily	_____ Respite Daily
Total Hours:	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**

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