HomeCare Resource, LLC

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Home Health Aide Time and Activity Documentation

Dates of service	MM/DD/YY (Saturday)	MM/DD/YY (Sunday)	MM/DD/YY (Monday)	MM/DD/YY (Tuesday)	MM/DD/YY (Wednesday)	MM/DD/YY (Thursday)	MM/DD/YY (Friday)
Activities							
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Other							

Visit One

Ratio staff to recipient	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3
Shared care location							
Time In (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Visit Two

Ratio staff to recipient	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3
Shared care location							
Time In (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Visit Three

Ratio staff to recipient	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3	(1:1) 1:2 1:3
Shared care location							
Time In (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

DAILY TOTAL (Minutes)	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes
Total Minutes This Timesheet		**Total 1:1**		**Total 1:2**		**Total 1:3**	

Acknowledgement and Required Signatures

After the HHA has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the HHA. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on HHA billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the HHA Care Plan.

RECIPIENT NAME (FIRST, MI LAST)	MA MEMBER # OR BIRTH DATE	HHA NAME (FIRST, MI, LAST)	HHA PROVIDER #

RECIPIENT/ RESPONSIBLE PARTY SIGNATURE	DATE	HHA SIGNATURE	DATE