

UNIQUEAID
Time Sheet

Week Ending Date

Week Ending Date Must Be a Sat

Month Day Year

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Client Last Name, First Name (PRINT NEATLY)

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Client Address:

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Employee Last Name, First Name (PRINT NEATLY)

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Client Number:

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Employee Number:

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	SUN	MON	TUE	WED	THU	FRI	SAT
Date	□□ □□	□□ □□	□□ □□	□□ □□	□□ □□	□□ □□	□□ □□
LiveIn/Night	L	L	L	L	L	L	L
Time In	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm
Time Out	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm	□□ □□ L am □□ □□ L pm
Total Time	□□ □□	□□ □□	□□ □□	□□ □□	□□ □□	□□ □□	□□ □□
Client Signature							

I, the above signed add my signature and guarantee the fact that the signing UniqueAID Employee has worked the hours shown above. The activities marked were performed on the days indicated.

Employee (Aide):

I, certify that hours shown above represent my total hours worked and they were properly confirmed by the client or an authorized representative.

	SUN	MON	TUE	WED	THU	FRI	SAT
1. Bath	L	L	L	L	L	L	L
2. Shower	L	L	L	L	L	L	L
3. Hair Care	L	L	L	L	L	L	L
4. Oral Hygiene	L	L	L	L	L	L	L
5. Nail Care	L	L	L	L	L	L	L
6. Assist with dressing	L	L	L	L	L	L	L
7. Ambulation/Assist with walking	L	L	L	L	L	L	L
8. Toileting	L	L	L	L	L	L	L
9. Transfer activities	L	L	L	L	L	L	L
10. Turn and position	L	L	L	L	L	L	L
11. Other (specify)	L	L	L	L	L	L	L
12. Foot Care	L	L	L	L	L	L	L
13. Special Skin Care	L	L	L	L	L	L	L
14. Assist with medication	L	L	L	L	L	L	L
15. Monitor bowel elimination	L	L	L	L	L	L	L
16. Assist with exercise	L	L	L	L	L	L	L
17. O2 Use	L	L	L	L	L	L	L
18. Assist with catheter care	L	L	L	L	L	L	L
19. Incontinent Care	L	L	L	L	L	L	L
20. Record Temp/Press/Resp	L	L	L	L	L	L	L
21. Other (specify)	L	L	L	L	L	L	L
22. Marketing	L	L	L	L	L	L	L
23. Light cleaning	L	L	L	L	L	L	L
24. Make bed, laundry, change lin	L	L	L	L	L	L	L
25. Tidy Bathroom & kitchen	L	L	L	L	L	L	L
26. Assist to relearn ADL's	L	L	L	L	L	L	L
27. Other (specify)	L	L	L	L	L	L	L
28. Record Intake/Output	L	L	L	L	L	L	L
29. Meal preparation & serving	L	L	L	L	L	L	L
30. Meal planning	L	L	L	L	L	L	L
31. Assist with feeding	L	L	L	L	L	L	L
32. Note appetite	L	L	L	L	L	L	L
Comments:							

(1.) We will not accept any progress note that does not match the care plan in the client's home.(2.) Times and activities must be completed on each shift. Report any changes or observations to supervisor and document changes and conversations with supervisor in the comments area. (3.) Do not anything that is not in client's care plan.