HOPE RISING
HOME CARE

TIME SHEET

Pay Period (Dates) _____Thru _____
(Monday through Sunday)

PRINT EMPLOYEE NAME: _____

EMPLOYEE PHONE NUMBER: _____

PRINT CONSUMER NAME: _____

PLEASE BE SURE TO INDICATE AM/PM NEXT TO EACH TIME ENTRY.

	MONTH OF:	MON	TUE	WED	THU	FRI	SAT	SUN
DATE:								
SHIFT ONE	Time in:							
	Time out:							
SHIFT TWO	Time in:							
	Time out:							
SHIFT THREE	Time in:							
	Time out:							
	TOTAL:							

CONSUMER NOTE: By your signature, you certify that hours shown are correct, and work was completed satisfactorily for the days and time documented:

CONSUMER SIGNATURE_____

THIS BOX IS FOR OFFICIAL USE OF PAYROLL VERIFIERS ONLY---------->

PAYROLL VERIFIER COMMENTS:

EMPLOYEE NOTE: By your signature, you certify that the hours recorded for the above dates are true and accurate and are properly verified by the client.

Employee Signature **Date**

TIMESHHETS ARE DUE BY 8 p.m. SUNDAY. Please drop off, FAX to 215-248-3301, or EMAIL to timesheets@hoperisinghomecare.com. You will NOT be paid without your timesheet.

ACTIVITY RECORD

Directions: This is a legal document. Check the assignment/care plan. Check each activity that is completed. Indicate "R" if an assigned activity is refused by the consumer. Indicate "H" for hospitalizations. Consumer changes, including hospitalizations should be called in to the Case Manager, IMMEDIATELY. **215-919-0086**

ACTIVITY / DAY	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Bathing							
Hair Care							
Dressing							
Lotion/Ointment							
Meal Preparation							
Eating/Drinking							
Laundry							
Light Housekeeping							
Shopping							
Medication Reminder							
Reading Writing							
Managing Finances							
Social Activities							
Telephone/Communication Devices							
Securing Transportation							
Appointment Scheduling							
Caring for Personal Possessions							
Obtaining Seasonal Clothing							
Ambulation							
Range of Motion							
Supervised Walks							
Supervision/Coaching							
Toileting							
Bowl/Bladder Management							
Transfers							
Incontinence Care							
Catheter Care							

CONDITIONS Consumer agrees to terms of NET UPON RECEIPT, and understands that unpaid accounts will be considered in default after thirty (30) days, after which a default charge will be imposed at 1½ % per month on unpaid balances (Annual rate of 18 %.) or the legal interest, whichever is lower. Client agrees to pay default charge and reasonable attorney's fee for cost of collection. Client recognizes the rights of Hope Rising Home Care as the employer and agrees to **NOT** employ the person named herein for a period of 90 days following termination of this assignment unless assessment fee is paid. Fee is $2500.00 for individuals; 25% of projected annual wage for facilities. **DO NOT** pay the employee directly. No credit can be assured against the current invoice. Employee BONDING claims are only assured if claims are made in writing and to the local police within 14 days after notice of loss.
FORM # _____