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CHHA/CNA

TRINITY CARE XYZ.

HOME HEALTH AIDE TIMESHEET

CLIENT NAME (First, MI, Last)	HHA (First, MI, Last)

DATES of SERVICE (month/date)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
TIME IN							
TIME OUT							
DAILY TOTAL HOURS							

**TOTAL HOURS FOR WEEK: [ ]

Instructions: Circle the specific task completed and Check each task performed on the day worked. R=Refused (document below)

TASK	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Bathing: Tub							
Shower							
Bed Bath / Sponge							
Oral Care: Mouth / Teeth / Dentures							
Foot Care: Lotion							
Groom: Shampoo							
Brush/Comb							
Shave / Dress							
Teds / Stockings							
Nails: *"File Only"* (Do Not Cut Nails)							
Skin Care: Lotion							
Toilet: Bathroom / Commode							
Urinal / Bedpan							
Incontinent/Briefs/Peri-Care							
Foley / Texas Catheter							
Ostomy Care							
Record: Intake / Output							
Bowels							
Transfers: Assist /Full / Hoyer/Bedbound							
Ambulation: Assist / Contact Guard							
Walker / Cane / Prosthesis / W/C							
Diet: " "							
Meal Prep: Bkfast/Lunch/Dinner/Snack							
Feeding: Assist / Cut / Feed Client							
Turn&Position: Every_____Hours							
Exercise/ROM: Assist / Remind							
Record Weight:							
Record: Temp. / Pulse / Resp. / B/P							
Record Glucose:							
Medication Reminders:							
Escort: Outdoors / MD							
Dispose Garbage:							
Tidy: Kit/ Bathrm/ Bedrm/ Living Room							
Vacuum / Mop / Dust:							
Change Bed Linens:							
Make Bed:							
Laundry:							
Shopping:							
Glasses / Hearing Aid- Left ear/Right ear							
Oxygen:_____Liter/Min_____Hours/Day							
Remind Client to wear PERS Unit:							
Other:							
Companion/Escort Only							

**HHA Comments: _____

_____

Client Signature:	Date:	HHA Signature:	Date:

***Time sheets can be received the first Friday and the second time sheet is received the following Thursday, by 3 pm.**

Office Use Only. Please Initial & Date

Admin	HHA Sup	RN Sup