Homemaker Time and Activity Documentation

Homemaker Name_____

AbbeyCare, Inc. 1148 Grand Ave St. Paul, MN 55105 651-690-5352 www.abbeycareinc.com

Days of Service	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Dressing/Undressing														
Grooming/Bathing														
Kitchen/Dishes														
Bathroom(s)														
Empty Wastebaskets														
Laundry														
Make Bed/Change Linen														
Vacuum/Dust														
Shopping/Errands														
Meal Preparation														
Monitor the Safety and Well Being														
Companionship/Social Stimulation														

DAY OF THE WEEK	**DATE**	**Time In** (Circle AM/PM)	**Time Out** (Circle AM/PM)	**Daily Total**
MONDAY		AM PM	AM PM	
TUESDAY		AM PM	AM PM	
WEDNESDAY		AM PM	AM PM	
THURSDAY		AM PM	AM PM	
FRIDAY		AM PM	AM PM	
SATURDAY		AM PM	AM PM	
SUNDAY		AM PM	AM PM	
MONDAY		AM PM	AM PM	
TUESDAY		AM PM	AM PM	
WEDNESDAY		AM PM	AM PM	
THURSDAY		AM PM	AM PM	
FRIDAY		AM PM	AM PM	
SATURDAY		AM PM	AM PM	
SUNDAY		AM PM	AM PM	
			TOTAL	

Acknowledgment and Required Signatures

After the Homemaker 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 Homemaker. Review the completed time sheet for accuracy before signing. ***It is a federal crime*** *to provide false information on 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 Care Plan.*

CLIENT NAME (First, MI, Last)	MA MEMBER # OR DOB	HOMEMAKER NAME (First, MI, Last)	
CLIENT / RESPONSIBLE PARTY SIGNATURE	DATE	HOMEMAKER SIGNATURE	DATE

Homemaker's Current Phone Number:_____