

# Silver Mountain Home Health Care LLC

1607 Chicago Ave S, Minneapolis, MN 55404 Phone: 612-226-5375 Fax: 651-204-9193

Email: [info@silvermountainhhc.com](mailto:info@silvermountainhhc.com) Web: [www.silvermountainhhc.com](http://www.silvermountainhhc.com)

## INDV HOME SUPTS W/O TRNG

Employee's Name: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Client Representative Name: \_\_\_\_\_

Date:	Time In	Time Out:		Date:	Time In:	Time Out:
03/07/2024	AM/PM	AM/PM		03/14/2024	AM/PM	AM/PM
03/08/2024	AM/PM	AM/PM		03/15/2024	AM/PM	AM/PM
03/09/2024	AM/PM	AM/PM		03/16/2024	AM/PM	AM/PM
03/10/2024	AM/PM	AM/PM		03/17/2024	AM/PM	AM/PM
03/11/2024	AM/PM	AM/PM		03/18/2024	AM/PM	AM/PM
03/12/2024	AM/PM	AM/PM		03/19/2024	AM/PM	AM/PM
03/13/2024	AM/PM	AM/PM		03/20/2024	AM/PM	AM/PM

Has the client been in the Hospital, a Care Facility or incarcerated during these two weeks?  If so, please complete the following: Date in _____ Date out _____			
Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on this timesheet. Your signature verifies the time and services entered above are accurate. "All time documented is assumed to be 1 staff to 1 client (1:1) unless otherwise noted time entry for that shift. For example, staff working with 2 clients at once should indicate 1:2 above time entries, 1:3 etc. A separate timesheet should be done for each client with whom the staff works.			
_____ Employee Signature	_____ Date	_____ Client/Client Rep	_____ Date