Silver Mountain Home Health Care LLC

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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:
02/22/2024	AM/PM	AM/PM		02/29/2024	AM/PM	AM/PM
02/23/2024	AM/PM	AM/PM		03/01/2024	AM/PM	AM/PM
02/24/2024	AM/PM	AM/PM		03/02/2024	AM/PM	AM/PM
02/25/2024	AM/PM	AM/PM		03/03/2024	AM/PM	AM/PM
02/26/2024	AM/PM	AM/PM		03/04/2024	AM/PM	AM/PM
02/27/2024	AM/PM	AM/PM		03/05/2024	AM/PM	AM/PM
02/28/2024	AM/PM	AM/PM		03/06/2024	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