

# 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:
05/16/2024	AM/PM	AM/PM		05/23/2024	AM/PM	AM/PM
05/17/2024	AM/PM	AM/PM		05/24/2024	AM/PM	AM/PM
05/18/2024	AM/PM	AM/PM		05/25/2024	AM/PM	AM/PM
05/19/2024	AM/PM	AM/PM		05/26/2024	AM/PM	AM/PM
05/20/2024	AM/PM	AM/PM		05/27/2024	AM/PM	AM/PM
05/21/2024	AM/PM	AM/PM		05/28/2024	AM/PM	AM/PM
05/22/2024	AM/PM	AM/PM		05/29/2024	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