

Bi-weekly Homemaker /Companion Report =

Client name _____

Homemaker _____

Homemaking Supervisor _____

MM/DD/YY									MM/DD/YY							
Week 1	SAT	SUN	MON	TUES	WED	THUR	FRI		Week 2	SAT	SUN	MON	TUES	WED	THUR	FRI
Time in									Time in							
Time out									Time out							
Socialization									Socialization							
Meal preparation									Meal preparation							
House cleaning									House cleaning							
Laundry									Laundry							
Errands									Errands							
Other									Other							

Complete the above according to the Homemaker Activity Plan. For additions, changes or deletions, contact the supervisor.

Comments: _____

After the Homemaker has document time and supports, the client must review the timesheet and draw a line through any item in which services were not received. Signatures verify that the information entered above are accurate and were performed as specified in the client care plan. **It is a crime to provide false information on PCA/Homemaker billings for Medical Assistance payment. National Home HealthCare, Inc. will investigate and report suspected fraud.**

I certify that the hours shown above are correct and that the employee's performance was satisfactory.

CLIENT SIGNATURE PMI: _____ DATE _____

HOMEMAKER SIGNATURE _____ DATE _____