Complete only if client was hospitalized:

Date	Time		Date	Time	
		Admit			Discharge

No hours can be claimed if Client is in the hospital, nursing home or out of home placement.

SINCERE HOME CARE
REAL PEOPLE. SUPREME SUPPORT.

HOMEMAKER TIME REPORT

Client Name: _____ Client DOB: _____

Fax: 763 – 208 – 6089 or Scan and Email to: timecards@sincerehomecaremn.com

Employee Name: _____ Pay Period Start/End Date(s): _____

This time report is to be completed DAILY and in its entirety. Incomplete time reports will be returned for completion. By signing below, the HOMEMAKER and CLIENT verifies that all the information entered on this form is accurate and truthful. *This time report must be received by no later than Tuesday, of the non-pay week, no later than 5 PM.*

Incomplete or late time reports may result in a delay of payment. Please see your time report example or call the office if assistance is needed.

Week One	Mo/Day/Yr.	Time In/Out Indicate AM or PM	Time In/Out Indicate AM or PM	Total Hrs.	Routine Household Care	Transportation Arrangement	Meal Preparation	Shopping & Errands	Assistance with ADLS	Companionship	Communication Assistance
Mon											
Tues											
Wed											
Thu											
Fri											
Sat											
Sun											
Total Time for Week One											

Week Two	Mo/Day/Yr.	Time In/Out Indicate AM or PM	Time In/Out Indicate AM or PM	Total Hrs.	Routine Household Care	Transportation Arrangement	Meal Preparation	Shopping & Errands	Assistance with ADLS	Companionship	Communication Assistance
Mon											
Tues											
Wed											
Thu											
Fri											
Sat											
Sun											
Total Time for Week One											

****NOTICE: Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the Homemaking Care Plan. It is a Federal Crime to provide false information for Medical Assistance payment.**

Homemaker Signature: _____ Date: _____ Client Signature: _____ Date: _____