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

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

Client Name: _____ **Client DOB:** _____

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

PLEASE READ: ***This time report must be received by no later than Tuesday, of the non-pay week, no later than 5 PM. Please see your time report example or call the office if assistance is needed.***

Complete time reports DAILY, White – out is Not Allowed, Picture Submissions are Not Allowed, Do not write X marks, ✓ marks; Initials Only, Use Blue or Black Pen Only, Complete time report in its entirety, Incomplete time reports will be returned, Late time reports will be paid the following pay period.

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: After the HMK has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the HMK. Review the completed timesheet for accuracy before signing. It is a federal crime to provide false information on HMK billings for Medical Assistance payment. Your signature verifies the time and service entered above are accurate and that the services were performed as specified in the HMK Care Plan.

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

For Office Use Only:

Billed = _____ Payroll = _____ S.S Entry = _____