Timesheet 2025

7 Railroad Ave., Ste. 220, Gorham, ME 04038
Phone: (207)222-0740 **Fax:** (207)222-0742
Email: ihsstc@gmail.com

Updated 2/19/24

Client's Name (First, Last)	Employee's Name (First, Last)

For the week of: **Sunday**_____/_____/_____ through **Saturday**_____/_____/_____
MM DD YY MM DD YY

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Dates of Service (MM/DD)	____/____	____/____	____/____	____/____	____/____	____/____	____/____
Time In							
Time Out							
Total Time							
Travel Time (In Minutes)							
Total Hours for Week (excluding Travel Time)							

	Personal Care Tasks	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	Cue For Meds							
Bathing	Sponge Bath							
	Bed Bath							
	Bath/Shower							
Hygiene	Shave							
	Oral Care							
	Nail Care							
	Hair Care							
	Skin Care							
	Dressing							
Toileting	Toilet/Commode							
	Catheter Care							
	Incontinent Products							
	Urinal							
Transfers	Assist							
	Pivot/Gait Belt							
	Hoyer Lift							
	Stand By							
Mobility	Bed							
	Exercise/Walk							
	Other							
Devices	Brace/Prosthetics							
	Eating Devices							
	TED Stockings							

INSTRUCTIONS:

Use code box below to document all completed tasks. Complete all tasks which are either checked or noted on your client's careplan.

CODE BOX

1 - Client performed task independently

2 - Client performed task with PSS oversight, encouragement or cueing.

3 - PSS performed task

R - Client Refused

To Claim Mileage:

To be paid for mileage, put the total mileage in the task boxes with the location driven to.

	Homemaking Tasks	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Kitchen	Trash							
	Dishes							
	Wipe Surfaces							
	Wipe Appliances							
	Floor Care							
Living Room	Dust							
	Floor Care							
Bedroom	Dust							
	Floor Care							
	Make/Change Bed							
Bath Room	Clean Fixtures							
	Floor Care							
	Laundry							
Meals	Dispose of Expired Food							
	Meals Required							
	Meal Preparation							
Mileage	Grocery Shopping							
	Locations:							
	Appointments							
	Locations:							
	Companion/Respite							
Health Maintenance								

Notes:

Client's Signature & Date:	Employee's Signature & Date:

Consumer Note: By your signature, you certify that the hours recorded above are correct and that the work was completed satisfactorily.

Employee Note: By your signature, you certify that the hours recorded for the above dates are accurate and were properly verified by the client.

All timesheets are to be turned into the office every Monday by 12PM Noon. Timesheets submitted after the deadline will be held until the following pay period. Please make certain that timesheets are completed accurately and that they are legible. Employees must sign with their FULL NAME. Please use black or blue ink. No SCRATCH-OUTS. No WHITE-OUT. No MARKER. If you make a mistake, draw a single line through it, initial it and make your correction. Any times/ dates that are inaccurate, added after the page is signed, or tasks marked off but not done are considered fraud and cause for immediate termination. This form is the property of In Home Senior Services Inc. This form and information therein, is confidential and proprietary.

OFFICE USE ONLY BELOW THIS LINE -- Employees Do Not Use

Total Weekly Hours _____ Total Travel Time _____ Total Mileage_____ EVV Approved _____

Notes:

Comments and/or Information

Please document any changes the office needs to know to keep records updated or to keep other family members of your clients informed of their condition on the lines below. If there is an emergency, call 911 and then the office. If you have a question about whether 911 needs to be called, you may call the office first.

Was the office called with this information? Yes _____ No _____ Date: _____/_____

Financial Transactions

Instructions: Fill out form below completely and accurately on the day shopping was done to record a financial transaction during which you handled your clients money. Please get two receipts. Give one to your client and attach one to your time sheet.

Reminder: Shopping should be done only once a week. The office will only reimburse for 10 miles at 70¢ a mile. Personal care tasks should be done first and homemaking tasks, including shopping, should be done second.

Transaction 1: (Please circle one) Cash Debit/Credit Card Personal Check EBT Card

Place: _____ Date: _____

If Using Cash, Amount Given: _____ Amount Returned: _____

If Using Other Payment Method, Transaction Amount: _____

Notes: _____

PSS Signature: Client Signature:

Transaction 2: (Please circle one) Cash Debit/Credit Card Personal Check EBT Card

Place: _____ Date: _____

If Using Cash, Amount Given: _____ Amount Returned: _____

If Using Other Payment Method, Transaction Amount: _____

Notes: _____

PSS Signature: Client Signature: