Family Personal Care

HRS: _____

PCA'S NAME: _____ **RECIPIENT'S NAME:** _____

☐ **PCA** ☐ **ATTENDANT** ☐ **HOMEMAKER** ☐ **PASS** ☐ **RESPITE** ☐ **OTHER** _____

Please check the appropriate boxes for services rendered during this period. Have our client sign for each visit daily and verify that the services were appropriate and necessary in nature.

Bathing/Dressing/ Grooming: Bano/Vestir/Peinar: (including wiping down the bathroom)

Eating Assistance: Asistencia al Comer:

Toileting/Continence: Uso de Bano:

Transfer Assistance: Tranferencia de Un lugar a Otro

Mobility Assistance: Asistencia en Caminar

Meal Preparation: Preparacion de Comida: (including washing dishes)

Housekeeping: Limpiesa General:

Laundry: Lavar Ropa:

Shopping: Ir de Compras:

	S	M	T	W	T	F	S
AM							
Noon							
PM							

Notes: _____

A.M. TIME

2020

Day	Date	Visit Time	Hrs	Client Signature	PCA'S Signature
S					
M					
T					
W					
TH					
F					
SA					

AFTERNOON TIME

Day	Date	Visit Time	Hrs	Client Signature	PCA'S Signature
S					
M					
T					
W					
TH					
F					
SA					

P.M. TIME

Day	Date	Visit Time	Hrs	Client Signature	PCA'S Signature
S					
M					
T					
W					
TH					
F					
SA					

I WAS ___ I WAS NOT____ Injured in anyway while on the job.

I certify that the time indicated on my time sheet is correct and the services checked were performed in the client's home, in accordance with the Client's Service Plan. I understand that submitting an incorrect time sheet constitutes fraud and that I may be prosecuted under the laws of the State of Nevada. I further understand that I must notify this Agency if my Client enters the hospital, hospice, or other facility and that I am unable to perform services while the Client is not at home.

Employee Signature _____

Supervisor Signature _____