Exceptional Hearts Home Care Agency

Time Sheet Documentation for Manual Electronic Visit Verification (EVV) Entries/ Edits

Employee Name:	Last 4 digits of SSN:
Consumer Name:	Medicaid ID:
Pay Period Start Monday:	Pay Period End Sunday:
Location of Service:	

DAY	DATE	START	FINISH	START	FINISH	TOTAL HOURS WORKED
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
					TOTAL HOURS WORKED	

DUTIES	Mon	Tues	Wed	Thur	Fri	Sat	Sun	DUTIES	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Meal Prep								Bathing							
Housework/Chores								Lotion/Ointment							
Managing Finances								Laundry							
Assist w/ Medications Reminders								Reading/Writing							
Shopping								Supervision/Coaching/Cue							
Transportation								Incontinence Care							
Hygiene								Grooming/ Nail Care							
Dressing, Upper								Skin Care							
Dressing, Lower								Assist with Walking							
Locomotion								Stairs							
Transfer								Hair Care							
Toilet Use								Change bed linens							
Bed Mobility								Phone Use							
Eating								Range of Motion							
Bladder Incontinence								Ambulating/ Walking							
Bowel Incontinence								Safety Check							
Personal Care T1019								Accompany to appointments							
Patient Support Activities								Mouth Care							

Was the consumer admitted to the hospital at any time this week? ☐ Y ☐ N If yes, Date:

Did you or the consumer sustain any injuries this week? ☐ Y ☐ N

Are there any safety hazards or issues to report within the consumer's home? ☐ Y ☐ N

Are there any changes that you would like to report to the agency? ☐ Y ☐ N

Consumer Signature:	Date:
Employee Signature:	Date:
I, the undersigned Direct Care Worker, attest that I provided Personal Assistance Services, as described above, to the Consumer listed on the time sheet above, and that the hours are true and correct.	
Provider Signature, Role	Date:

Falsified documentation is grounds for immediate termination.

Time Sheets are due every MONDAY by 5:00pm.

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