



S&A UNIFIED HOME CARE, INC.

2729 CONEY ISLAND AVENUE, BROOKLYN, NY 11235

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HHA/PCA DUTY-SHEET

HHA/PCA NAME (Last, First) PRINTED:		PATIENT NAME (Last, First) PRINTED:	
COORDINATOR:	YEAR: 202__	PATIENT ADDRESS:	
DATE: __/__/__ MONTH DAY YEAR	TIME IN: __:__ AM PM	TIME OUT: __:__ AM PM	TOTAL HOURS
(OPTIONAL: SHIFT 2)	TIME IN: __:__ AM PM	TIME OUT: __:__ AM PM	TOTAL HOURS

PATIENT SIGNATURE → **SIGN HERE** _____

For Live-In Cases: ☐ I certify that I recieved 5 hrs of uninterrapted sleep and 3 hrs meal-break every day of service.

NOTE: Patient's signature is required for each DATE when service was provided.

Patient's signature certifies that the hours of service noted above have been received.

HHA/PCA SIGNATURE: → **SIGN HERE** _____

TASKS (Must be checked)

DESCRIPTION		S	M	T	W	T	F	S	DESCRIPTION		S	M	T	W	T	F	S
BATH	BED -100 / SHOWER -101 / CHAIR -102								HOUSEHOLD	CHANGE BED LINEN -500 / LAUNDRY -501							
	MOUTH CARE / DENTURE CARE -106									LIGHT HOUSEKEEPING -502 / CLEAN EQ.-505							
	PT.REFUSED PERSONAL CARE -590									PCA ONLY:SHOPPING -506 / MD APPT.-508							
GROOMING	HAIR CARE COMB -107 / SHAMPOO -108								SPECIAL NEEDS	DIVERSIONAL ACTIVITIES(SPEAK/READ)-509							
	SHAVING(SAFE) -109 /NAILS(DO NOT CUT) -110									REQ. 1-2 TO TRANSFER -300 /AMBULATE -301							
	DRESSING(PATRIAL OR COMPLETE) -111									ASSISTING DEVISE IN USE -302							
MEALS	SKIN CARE -112 / FOOT CARE -113								OTHER	TURNING AND POSITIONING -311							
	PREPARE: BREAKFAST -202 / LUNCH -203									HHA ONLY: TAKE: TEMP.-400 / PULSE -403							
	DINNER -204 / SNACK -205									BLOOD PRESS.-405 / WEIGHT -406							
TOILETING	ASSIST WITH FEEDING/FLUIDS -206								OTHER	ASSIST: TRACHEOSTOMY CARE -569							
	DIET: REGULAR -529 / LOW SALT -530									TUBE FEEDING-570 / NEBUILIZER -571							
	LOW CHOLESTEROL -533 / ADA CAL. -535									REMIND TO TAKE MEDICATION -411							
PREC.	DIAPER-114/COMMODE-115/BEDPAN-116								OTHER	MONITOR PATIENT SAFETY- 511							
	TOILETING -117 /ASSIST W/CATHETER -408									HAND WASHING (during service hrs) -888							
	EMPTY:FOLEY BAG -409 /COLOSTOMY -410									LIVE-IN ONLY:YES, I RECIEVED 8 HRS OF SLEEP WITH 5 HRS BEING UNINTER.-801							
PREC.	INCONTINENCE:BLADDER-130/ BOWEL-131								OTHER	YES,I RECIEVED 3 UNINER.MEALS -802							
	PRECAUTIONS: FALL -539 / SEIZURE -540									OTHER NOTES:							
	BLEEDING-541/OXYGEN-543/SKIN CON.-544																

REASON FOR TIMESHEET (must be marked)

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|--|---|
| ☐ Called In or Out of the EVV system early or late | ☐ Consumer received services outside of the home |
| ☐ Unable to connect to internet or EVV system is down | ☐ Sabbath Observant |
| ☐ Clockd In/Out using wrong Time pin ID | ☐ FOB device malfunctioned |
| ☐ Phone in use by consumer or individual in consumer home | ☐ GPS address did not link Consumer's phone line not working |

NO SERVICES WILL BE PAID WHEN CLIENT IS HOSPITALIZED. ONLY AUTHORIZED HOURS WILL BE PAID.

21st Century Cures Act Sec. 12006. Electronic visit verification required for personal care services and home health care services under Medicaid and went into effect on January 1st, 2021.

I CERTIFY THAT ABOVE INFORMATION IS ACCURATE: PATIENT UNABLE TO SIGN DUE TO MED.CONDITION: ☐BLIND ☐BED-BOUND ☐OTHER _____

NOTE: USE BLACK INK ONLY.

TIMESHEETS MUST BE SUBMITTED **LATEST ON MONDAY** at 12PM.

ORIGINAL TIMESHEETS MUST BE MAILED TO THE OFFICE.

TIMESHEETS MUST BE SIGNED & DATED BY PATIENT AND AIDE.

TIMESHEETS MAY NOT HAVE ANY WHITE-OUT ON IT. DO NOT WHITE OUT PREVIOUSLY DATED TIMESHEETS.