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 certifies that the hours of service noted above have been received.

HHA/PCA SIGNATURE: → SIGN HERE _____

TASKS (REQUIRED to be checked):

	DESCRIPTION	S	M	T	W	T	F	S
BATH	BED -**100** / SHOWER -**101** / CHAIR -**102**							
	MOUTH CARE / DENTURE CARE -**106**							
	PT.REFUSED PERSONAL CARE -**590**							
GROOMING	HAIR CARE COMB -**107** / SHAMPOO -**108**							
	SHAVING(SAFE) -**109** /NAILS(DO NOT CUT) -**110**							
	DRESSING(PATRIAL OR COMPLETE) -**111**							
	SKIN CARE -**112** / FOOT CARE -**113**							
MEALS	**PREPARE:** BREAKFAST -**202** / LUNCH -**203**							
	DINNER -**204** / SNACK -**205**							
	ASSIST WITH FEEDING/FLUIDS -**206**							
	DIET: REGULAR -**529** / LOW SALT -**530**							
	LOW CHOLESTEROL -**533** / ADA CAL. -**535**							
TOILETING	DIAPER-**114**/COMMODE-**115**/BEDPAN-**116**							
	TOILETING -**117** /ASSIST W/CATHETER -**408**							
	EMPTY:FOLEY BAG -**409** /COLOSTOMY -**410**							
	INCONTINENCE:BLADDER-**130**/ BOWEL-**131**							
PREC.	**PRECAUTIONS: FALL -539** / SEIZURE -**540**							
	BLEEDING-**541**/OXYGEN-**543**/SKIN CON.-**544**							

	DESCRIPTION	S	M	T	W	T	F	S
HOUSEHOLD	CHANGE BED LINEN -**500** / LAUNDRY -**501**							
	LIGHT HOUSEKEPING -**502** / CLEAN EQ.-**505**							
	PCA ONLY:SHOPPING -**506** / MD APPT.-**508**							
	DIVERSIONAL ACTIVITIES(SPEAK/READ)-**509**							
SPECIAL NEEDS	REQ. 1-2 TO TRANSFER -**300** /AMBULATE -**301**							
	ASSISTING DEVISE IN USE -**302**							
	TURNING AND POSITIONING -**311**							
	HHA ONLY: TAKE: TEMP.-**400** / PULSE -**403**							
	BLOOD PRESS.-**405** / WEIGHT -**406**							
	ASSIST: TRACHEOSTOMY CARE -**569**							
	TUBE FEEDING-**570 /** NEBUILIZER -**571**							
OTHER	**REMIND TO TAKE MEDICATION -411**							
	MONITOR PATIENT SAFETY- 511							
	HAND WASHING (during service hrs) -**888**							
	LIVE-IN ONLY:YES, I RECIEVED 8 HRS OF							
	SLEEP WITH 5 HRS BEING UNINTER.-**801**							
	YES,I RECIEVED 3 UNINTER.MEALS -**802**							
	OTHER NOTES:							

NY MEDICAID AND FEDERAL LAW REQUIRE EVV (CLOCK-IN/OUT) FOR ALL HOME CARE VISITS. PAPER TIMESHEETS DO NOT REPLACE EVV.

REASON FOR MISSED CLOCK-IN OR CLOCK-OUT (REQUIRED to be specified):

INCOMPLETE EXPLANATIONS WILL NOT BE ACCEPTED

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

I CERTIFY THAT ABOVE INFORMATION IS ACCURATEPATIENT 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.

S&A United Home Care, Inc.