S&A UNIFIED HOME CARE, INC.

2036 MCDONALD AVENUE, BROOKLYN NY 11223
Ph: (718)-980-6100 Fax: (718)873-9311

HHA/PCA DUTY-SHEET

HHA/PCA NAME (Last, First) PRINTED:		PATIENT NAME (Last, First) PRINTED:
COORDINATOR: ☐BROOKLYN ☐BRONX ☐QUEENS ☐LONG ISL.	YEAR: 2020	PATIENT ADDRESS:

	SATURDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
DATES OF SERVICE (MM/DD)							
TIME IN (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
TIME OUT (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
DAILY TOTAL HOURS							
PATIENT SIGNATURE							

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:** _____

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

TASKS (Must be checked)

	DESCRIPTION	S	S	M	T	W	T	F
BATH	☐ TUB -100 ☐ SHOWER -101							
	☐ TOTAL CARE -103 ☐ BED -102							
	☐ ASSIST							
PERSONAL CARE	MOUTH CARE / DENTURE CARE - 106							
	HAIR CARE COMB- 107							
	SHAMPOO- 108							
	GROOMING SHAVE - 109							
	NAILS- 110							
	DRESSING - 111							
	SKIN CARE - 112							
	FOOT CARE - 113							
TOILETING	☐ DIAPER- 114							
	☐ COMMODE - 115							
	☐ BEDPAN/URINAL- 116							
	☐ TOILET- 117							
MEALS	**NUTRITION**							
	DIET: ☐ REG ☐ PRESCRIBED-							
	201 PAREPARE: ☐ BREAKFAST- 202							
	☐ LUNCH- 203 ☐ DINNER- 204							
	PREPARE SNACK- 205							
	ASSIST WITH FEEDING-							
	206 RECORD INTAKE:							
	☐ FOOD-207 ☐ FLUID-208							
AMBULATION	TRANSFERRING- 300							
	ASSIST WITH WALKING- 301							
	TURNING AND POSITIONING- 311							
	DEVICE IN USE- 302							
	☐ CANE ☐ WALKER ☐ CRUTCHES							
	ASSIST WITH HOME EXERCISE							
	PROGRAM - 305							
	ASSIST WITH ROM - 306							
	EXERCISE: ☐ R. ARM ☐ L. ARM							
	DR. FOOT ☐ L. FOOT ☐ NECK							

	DESCRIPTION	S	S	M	T	W	T	F
SPECIAL NEEDS	TAKE TEMPERATURE- 400							
	☐ ORAL ☐ RECTAL ☐ AXILLARY							
	TAKE PULSE- 403							
	TAKE RESPIRATIONS -404							
	TAKE BLOOD PRESSURE- 405							
	WEIGHT PATIENT- 406							
	RECORD OUTPUT (URINE/BM)-407							
	ASSIST WITH CATHETER CARE- 408							
	EMPTY POLEY BAG - 409							
	ASSIST WITH OSTOMY CARE- 410							
	REMIND TO TAKE MEDICATION- 411							
	ASSIST WITH TREATMENTS,							
	SPECIFY AS WRITTEN ON POC:							
HOUSEHOLD	CHANGE BED LINEN - 500							
	PATIENT LAUNDRY- 501							
	LIGHT HOUSEKEPING- 502							
	☐ PATIENT ROOM ☐ KITCHEN							
	☐ BATHROOM							
	☐ PATIENT CARE EQUIPMENT- 505							
	DO PATIENT SHOPPING- 506							
	DO PATIENT ERRANDS- 506							
	ACCOMPANY PATIENT TO							
ACTIVITIES	MEDICAL APPOINTMENT- 508							
	DIVERSIONAL ACTIVITIES -509							
	(SPECIFY)							
	☐ READING ☐ TALKING							
	MONITOR PATIENT SAFETY- 511							
OTHER	MODERATE EXERCISE/WALKING							
	Please mention if any changes to the							
	Patient' health conditions occurred							
	during this service week:							
	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** OF THE FOLLOWING WORKED WEEK. **ORIGINAL** TIMESHEETS MUST BE MAILED TO THE OFFICE.TIMESHEET **WITHOUT** PATIENT'S SIGNATURE WILL **NOT BE ACCEPTED**.
IF YOUR TIMESHEETS ARE LATE YOU WILL NOT BE PAID FOR THIS PERIOD. **IT IS A FEDERAL CRIME TO PROVIDE FALSE INFORMATION ON THE TIMESHEET.**