



S&A UNIFIED HOME CARE, INC.
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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

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:** _____

TASKS (Must be checked)

DESCRIPTION		S	M	T	W	T	F	S	DESCRIPTION		S	M	T	W	T	F	S
BATH	TUB -100 / SHOWER -101								HOUSEHOLD	CHANGE BED LINEN -500							
	TOTAL CARE -103									PATIENT LAUNDRY -501							
	MOUTH CARE / DENTURE CARE - 106									LIGHT HOUSEKEEPING -502							
PERSONAL CARE	HAIR CARE COMB-107 / SHAMPOO-108								ACTIVITIES	DO PATIENT SHOPPING / ERRANDS -506							
	GROOMING SHAVE -109/ NAILS - 110									ACCOMPANY TO MED.APPOINTMENT-508							
	ASSIST WITH DRESSING -111									TRANSFERRING -300							
	SKIN CARE -112 / FOOT CARE -113									ASSIST WITH WALKING -301							
MEALS	DIAPER- 114 / COMMODE -115								OTHER	MODERATE EXERCISE/WALKING -305							
	BEDPAN / URINAL -116 / TOILET- 117									TURNING AND POSITIONING -311							
	PRESCRIBED DIET -201									TAKE TEMPERATURE -400							
	PREPARE BREAKFAST -202									REMINO TO TAKE MEDICATION -411							
	PREPARE LUNCH -203									DIVERSIONAL ACTIVITIES SPEAK/READ)-509							
PREPARE DINNER -204								MONITOR PATIENT SAFETY- 511									
PREPARE SNACK -205								ASSIST WITH TREATMENT AS PER POC									
ASSIST WITH FEEDING -206																	
RECORD INTAKE: FOOD-207 / FLUID-208																	

REASON FOR TIMESHEET (must be marked)

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

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.