SAFE HEAVEN HOME CARE SERVICES

OFFICE USE ONLY **Program: Individualized Home Supports (IHS)**

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Employee's Name: _____

Client's Name: _____

Client Representative Name: _____

Date:	Time In	Time Out:		Date:	Time In:	Time Out:
	AM/PM	AM/PM			AM/PM	AM/PM
	AM/PM	AM/PM			AM/PM	AM/PM
	AM/PM	AM/PM			AM/PM	AM/PM
	AM/PM	AM/PM			AM/PM	AM/PM
	AM/PM	AM/PM			AM/PM	AM/PM
	AM/PM	AM/PM			AM/PM	AM/PM
	AM/PM	AM/PM			AM/PM	AM/PM

Has the client been in the Hospital, a Care Facility or incarcerated during these two weeks?

If so, please complete the following: Date in_____Date out _____

Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on this timesheet. Your signature verifies the time and services entered above are accurate. "All time documented is assumed to be 1 staff to 1 client (1:1) unless otherwise noted time entry for that shift. For example, staff working with 2 clients at once should indicate 1:2 above time entries, 1:3 etc. A separate timesheet should be done for each client with whom the staff works.

_____

Employee Signature Date Client/Client Rep Date