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HOMEMAKING TIMESHEET (BI-WEEKLY)

CLIENT NAME: _____

EMPLOYEE NAME: _____

PERIOD COVERED: _____ TO _____

Please write your initials next to all the activities you provided on a daily basis.

PROCEDURES / DAYS	MON	TUES	WED	TH	FRI	SAT	SUN	MON	TUES	WED	TH	FRI	SAT	SUN
Review Care Plan Daily!														
DAILY														
Prepare and serve food														
Wash and put away dishes after meal														
Wipe off counter tops after each meal														
Clean kitchen sink after each meal														
Clean stove and microwave														
Sweep kitchen and bathroom floors/shake rugs														
Empty garbage baskets														
Clean toilet and sink (inside & outside)														
Clean commode/urinal extenders														
Make beds														
Straighten bedrooms														
Straighten living areas														
Vacuum each room and edges along wall														
Dust each room														
Laundry (inc. bed linens)														
WEEKLY														
Clean refrigerator (throw out bad food)														
Clean telephone / sanitize														
Take garbage and recycling outside														
Change bed linens														
Clean mirrors														
Grocery shopping														

CHECK HERE IF YOU HAVE ADDITIONAL CLIENT OBSERVATIONS / CONCERNS. PLEASE DOCUMENT THESE ON BACK OF THE WHITE CHARTING SHEET AND NOTIFY YOUR SUPERVISOR OF ANY UNSUAL BEHAVIORS / OBSERVATIONS / CONCERNS IMMEDIATELY.

DAY	DATE	TIME WORKED		DAILY TOTAL TIME IN HOURS & MINUTES (HH:MM)
		IN	OUT	
MONDAY	/ /20__	AM PM	AM PM	
TUESDAY	/ /20__	AM PM	AM PM	
WEDNESDAY	/ /20__	AM PM	AM PM	
THURSDAY	/ /20__	AM PM	AM PM	
FRIDAY	/ /20__	AM PM	AM PM	
SATURDAY	/ /20__	AM PM	AM PM	
SUNDAY	/ /20__	AM PM	AM PM	
MONDAY	/ /20__	AM PM	AM PM	
TUESDAY	/ /20__	AM PM	AM PM	
WEDNESDAY	/ /20__	AM PM	AM PM	
THURSDAY	/ /20__	AM PM	AM PM	
FRIDAY	/ /20__	AM PM	AM PM	
SATURDAY	/ /20__	AM PM	AM PM	
SUNDAY	/ /20__	AM PM	AM PM	
TOTAL HOURS & MINUTES				

Acknowledgement and Required Signatures:

After the employee has completed the 2-week pay period, the client/recipient should **draw a line** through the dates and times he/she did not receive assistance. Both client (or his/her responsible party) and employee must sign this timesheet in order for this timesheet to be valid.

IT IS A FEDERAL CRIME TO PROVIDE FALSE INFORMATION ON HOMEMAKING BILLINGS FOR MEDICAL ASSISTANCE PAYMENT.

RECIPIENT / CLIENT NAME	DOB OR MA#
RECIPIENT / RESPONSIBLE PARTY SIGNATURE	DATE
EMPLOYEE NAME	
EMPLOYEE SIGNATURE	DATE