**Effective 2018** **REG.#HCA0000260**

# Overnights

EURO HOMECARE LLC.
17 Pierce Street
Plainville, CT 06062
(860) 793-9944

**TIME SHEET / PLAN OF CARE**

Customer Name _____

Week Ending ___/___/20___

Employee Name _____

| | | SATURDAY | SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY |
|---|---|---|---|---|---|---|---|---|---|
| | Date | | | | | | | | |
| | Time In | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| | Time Out | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| | Hours Worked | | | | | | | | |
| **ADLs** | Bathing | | | | | | | | |
| | Dressing | | | | | | | | |
| | Eating / Feeding | | | | | | | | |
| | Grooming | | | | | | | | |
| | Mobility / Walking | | | | | | | | |
| | Toileting / Bowel and Bladder Care | | | | | | | | |
| | Trasnsferring | | | | | | | | |
| | Oral Care | | | | | | | | |
| | | | | | | | | | |
| **IADLs** | Cueing / Reminders for Self Medication Administration | | | | | | | | |
| | Housekeeping | | | | | | | | |
| | Laundry | | | | | | | | |
| | Meal Preparation / Planning | | | | | | | | |
| | Shopping | | | | | | | | |
| | | | | | | | | | |
| **Other** | Accompany to Appointments | | | | | | | | |
| | Walks | | | | | | | | |
| | Conversation | | | | | | | | |
| | Errands | | | | | | | | |
| | Mail / Correspondence | | | | | | | | |
| | Assistance with Phone Calls | | | | | | | | |
| | Reading | | | | | | | | |
| | _____ | | | | | | | | |
| | _____ | | | | | | | | |
| | | Customer Signature | Customer Signature | Customer Signature | Customer Signature | Customer Signature | Customer Signature | Customer Signature | Customer Signature |

**ADL / IADL Codes**
**R = Routine**
**F = Frequent**
**I = Intermittent**

**I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.**
**!OBSERVE AND REPORT CHANGES IN CLIENT'S CONDITION TO THE AGENCY SUPERVISOR!**
**Time sheets must be received by 9AM Tuesday. NO EXCEPTIONS.**
**Drop off at the office or fax to (860)793-9943**
**If you need to make any changes, make ONE cross through the mistake,**
**and both caregiver and client need to sign it. Use blue ink to complete.**

Employee Signature _____ Date _____

Agency Spervisor Signature _____ Date _____