MIND&MOBILITY
Home Care Centers

Mind & Mobility Timesheet

It is mandatory to receive signatures for every client visit.

Week Starting Date (Monday):

Week Ending Date (Sunday):

Sheets must be scanned and e-mailed by the end (sooner if possible) of each week to: Your local office

Caregiver's Full Name:

Client's Full Name: **Client's Address:**

No cross-outs allowed - Details of Services Provided:

Day	Date (mm/dd/yy)	PC		HMKG		COMP		RESP		Total Hours Per Day	Client Signature(s): Daily Signatures **Required** of the Client or an Adult Representative Attesting to Service Satisfaction and Correct Service Hours as Listed.
		Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time		
MON											Client Signature:
TUE											Client Signature:
WED											Client Signature:
THU											Client Signature:
FRI											Client Signature:
SAT											Client Signature:
SUN											Client Signature:
									Total Hours for the Week:		

Caregiver Signature:		**CAREGIVER SIGNATURE CERTIFIES ACCURACY FOR THE ABOVE RECORD OF TIME AND SERVICE(S) PROVIDED. PURPOSELY FALSIFYING ENTRIES WILL RESULT IN DISCIPLINARY ACTION UP TO AND/OR INCLUDING TERMINATION OF EMPLOYMENT.**

**** Even if you are using the app to clock in/out, this sheet is MANDATORY for ALL VISITS you don't get the client's signature. ****

Complete the portion below only if your application is NOT used for ADL's **Day of Week:**	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Brain Fitness Activities	☐	☐	☐	☐	☐	☐	☐
Movement and Mobility Fitness Activities	☐	☐	☐	☐	☐	☐	☐
Bathing: ☐ Bed Bath ☐ Partial/Sponge ☐ Shower/Bath ☐ Assisted	☐	☐	☐	☐	☐	☐	☐
Grooming ☐ **Shave** ☐	☐	☐	☐	☐	☐	☐	☐
Hair Care: ☐ Combed ☐ Washed	☐	☐	☐	☐	☐	☐	☐
Oral Care ☐	☐	☐	☐	☐	☐	☐	☐
Toileting: ☐ Peri-care ☐ Empty/Measure Drainage Bag ☐ Record Output ☐ Chart Bowel Movements	☐	☐	☐	☐	☐	☐	☐
Turn Position of Client	☐	☐	☐	☐	☐	☐	☐
Assist with Walking	☐	☐	☐	☐	☐	☐	☐
Assist with Transfers: ☐ Pivot ☐ Board ☐ Hoyer	☐	☐	☐	☐	☐	☐	☐
Encourage Active Range of Motion	☐	☐	☐	☐	☐	☐	☐
Remind Client to Take Medication	☐	☐	☐	☐	☐	☐	☐
Prepare/Serve Meals ☐	☐	☐	☐	☐	☐	☐	☐
Bed: ☐ Make ☐ Change Linens	☐	☐	☐	☐	☐	☐	☐
Clean/Tidy: ☐Bedroom☐ Bathroom ☐ Kitchen ☐ Wash Dishes ☐ Vacuum ☐ Sweep ☐ Mop/Dust Weekly	☐	☐	☐	☐	☐	☐	☐
Empty Trash/Ash Trays ☐	☐	☐	☐	☐	☐	☐	☐
Shopping/Errands	☐	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐	☐
Keep Floor Free of All Obstacles	☐	☐	☐	☐	☐	☐	☐
No Change to client's Condition	☐	☐	☐	☐	☐	☐	☐

NOTE: Call office immediately with changes in client's condition. Document the name and date of office staff member(s) you notified below: