Pro-Health Home Care Agency: 4710 Central Ave NE , Columbia Heights MN 55421

Email / ts@prohealthcare.net (FAX: 763-746-8154), Phone Number: 763-746-8155 After Hours Phone: 612-757-2320

☐ Respite ☐ IHS w/o Training ☐ Night Supervision ☐ ICLS ☐ ☐

2024

Mo/Day /Yr	Week 1	Time In	Time Out	Time In	Time Out	Total DH	Client's Covid Screening Symptoms*	Client Temp. F	HHA's Covid Screening Symptoms*	HHA Temp. F	HHA Initials
/ /2024	Mon	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Tue	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Wed	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Thu	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Fri	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Sat	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Sun	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		

Please use standard 12 hr time and circle AM or PM.

HHA's: Initial each box supports were provided by you/ visit.

Mo/Day /Yr	Week 2	Time In	Time Out	Time In	Time Out	Total DH	Client's Covid Screening Symptoms*	Client Temp. F	HHA's Covid Screening Symptoms*	HHA Temp. F	HHA Initials
/ /2024	Mon	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Tue	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Wed	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Thu	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Fri	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Sat	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		
/ /2024	Sun	am pm	am pm	am pm	am pm		☐Yes ☐No		☐Yes ☐No		

After the HHA has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the HHA. Review the completed time sheet for *accuracy before signing. It is a federal crime to provide false information on HHA billings for Medical* Assistance payment. Your Signature verifies the time and services entered above are accurate and that the services were performed as specified in the HHA Care Plan.

Client stay in Hospital/Care Facility/Incarceration

Place:

Date in:

Time in:

Date out:

Time out:

Print HHA Name:

HHA Signature: **Date: / /2024**

Print Client Name: **MA # or DOB:**

HHA or Responsible Party Signature: **Date: / /2024**

Timesheets are due on Moday After The Last Sunday On The Timesheet at 4:30 PM

OFFICE USE ONLY

HHA Phone Number _____. Is there a change of HHA or Client Address? Yes No, If Yes , please u☐date ☐dress on the line below.

*HHA to ask client & her/himself: Have you felt like having fever in the past day? Do you have a new or worsening cough today? Then HHA should screen client & her/himself if having any of the following symptoms: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache,Congestion or runny nose, Nausea or vomiting, Diarrhea, New loss of taste or smell, Sore throat. (last CDC update 2/22/2021).