HMONG HOME HEALTH CARE, LLC.

Respite Timesheet

Office Phone: 651-488-1680
Fax: 651-488-4087
timecards@hh-hc.com

Recipient Name: _____ **Employee:** _____

Week 1 of Paycycle		**Mon** (MM/DD/YY)	**Tues** (MM/DD/YY)	**Wed** (MM/DD/YY)	**Thurs** (MM/DD/YY)	**Fri** (MM/DD/YY)	**Sat** (MM/DD/YY)	**Sun** (MM/DD/YY)
Date								
Visit 1	In	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
	Out	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
Visit 2	In	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
	Out	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
Daily Total								
Weekly Total		*Initial the task/action that you completed/assisted the recipient*						
Self Care/Hygiene								
Meal Prep								
Safety Skills								
Health Related								
Other (goal, etc.)								
Date & Notate Activity:								

Week 2 of Paycycle		**Mon** (MM/DD/YY)	**Tues** (MM/DD/YY)	**Wed** (MM/DD/YY)	**Thurs** (MM/DD/YY)	**Fri** (MM/DD/YY)	**Sat** (MM/DD/YY)	**Sun** (MM/DD/YY)
Date								
Visit 1	In	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
	Out	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
Visit 2	In	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
	Out	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm
Daily Total								
Weekly Total		*Initial the task/action that you completed/assisted the recipient*						
Self Care/Hygiene								
Meal Prep								
Safety Skills								
Health Related								
Other (goal, etc.)								
Date & Notate Activity:								

Incidents/Accidents? Medical Emergencies?	
Emergency Use of Controlled Procedure?	

Overall Total

CERTIFICATION: This is to certify that all information on this form is true, accurate, and complete.

Employee Signature:_____ Date:_____

Office Address:
475 Etna St. Suite #3
St. Paul, MN 55106