International Quality Homecare
Omega Home Health Services

HHA Time and Activity Documentation

SVC Code:

Dates/Location of recipient stay in hospital/care facility/incarceration:	Services: ☐ HHA Visit ☐ HHA-extended

ALL TME SHEETS MUST BE IN THE OFFICE BY 12:00 PM EVERY MONDAY

Date of Service (in consecutive order)	MON	MM / DD / YY	TUE	MM / DD / YY	WED	MM / DD / YY	THU	MM / DD / YY	FRI	MM / DD / YY	SAT	MM / DD / YY	SUN	MM / DD / YY
Visit One (Only one HHA Visit per day)														
Time in (Circle AM/PM)		AM PM		AM PM		AM PM		AM PM		AM PM		AM PM		AM PM
Time out (Circle AM/PM)		AM PM		AM PM		AM PM		AM PM		AM PM		AM PM		AM PM

Total Miles:							
Daily Total (Hours)							
Total Hours on This Time Sheet							

MINNESOTA

HHA ACTIVITY REPORT

SERVICES	M A	M P	T A	T P	W A	W P	T A	T P	F A	F P	S A	S P	S A	S P
Empty Bedside Commode														
Bath: (Circle one) Tub, Sponge Bed, Shower														
Shampoo Hair Care														
Shave														
Mouth Care														
Nail Care														
Dressing: Lower Extremities Upper Extremities														
Medication Reminder														
Toileting: Independent Assist Total Dependence														

SERVICES	M A	M P	T A	T P	W A	W P	T A	T P	F A	F P	S A	S P	S A	S P
Skin Care: (Circle accordingly) Dry, Red, Bruised, Broken, Itching														
Eating: Independent Assist-Cut up Feed G-Tube														
Transfers: Independent Assist (1) Assist (2) Hoyer Lift														
Mobility: Ambulation Independent Assist														
Reposition: Independent Assist														

SERVICES	M A	M P	T A	T P	W A	W P	T A	T P	F A	F P	S A	S P	S A	S P
ROM / Exercise (check one)														
Appetite: Good Fair Poor														
Bed Bound														
Catheter Care														
Empty Catheter Bag														
Bowel Movement: (Circle one) Normal, Normal, Constipation, Diarrhea														
Mental Status: (Check accordingly) Alert / Oriented Alert / Confused Forgetful Disoriented														

Comments: (include dates)

ONLY IF REQUESTED ON SERVICE PLAN

URINE TEST

Type _____
Color _____
Odor _____
Cloudy _____
Not Observed _____

RESULTS:

VITAL SIGNS

Temperature _____
Pulse _____
Respiration _____
BIP _____
Blood Sugar _____
Blood Sugar Checks _____

Intake _____
Output _____
Encourage Fluids _____

Acknowledgement and Required Signature

After the Caregiver 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 Caregiver. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on 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 Care Plan.

PRINT RECIPIENT NAME (First, MI, Last)	MA MEMBER # OR BIRTH DATE	PRINT CAREGIVER NAME (First, MI, Last)	
RECIPIENT/RESPONSIBLE PARTY SIGNATURE	DATE	CAREGIVER SIGNATURE	DATE