International Quality Homecare
Omega Home Healthcare

HHA-HCN 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												
Scheduled Visit (in Hours)	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6	Visit 7	Visit 8	Visit 9	Visit 10	Visit 11	Visit 12
Visit Start Time (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Visit End Time (Circle AM / PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Total Hours on This Time Sheet	

HHA ACTIVITY REPORT

SERVICES	1	2	3	4	5	6	7	8	9	10	11	12
Bath:												
Tub												
Sponge												
Bed												
Shower												
Shampoo												
Hair Care												
Shave												
Mouth Care												
Skin Care:												
Dry												
Red												
Bruised												
Broken												
Itching												
Nail Care												
Dressing:												
Lower Extremities												
Upper Extremities												

SERVICES	1	2	3	4	5	6	7	8	9	10	11	12
Appetite:												
Good												
Fair												
Poor												
Eating:												
Independent												
Assist-Cut up												
Feed												
G-Tube												
Toileting:												
Independent												
Assist												
Total Dependence												
Bowel Movement:												
Normal												
Constipation												
Diarrhea												
Catheter Care												
Empty Catheter Bag												
Empty Bedside Commode												

SERVICES	1	2	3	4	5	6	7	8	9	10	11	12
Mobility:												
Ambulation												
Independent												
Assist												
Reposition:												
Independent												
Assist												
Bed Bound												
Transfers:												
Independent												
Assist (1)												
Assist (2)												
Hoyer Lift												
ROM												
Exercise												
Mental Status:												
Alert / Oriented												
Alert / Confused												
Forgetful												
Disoriented												
Medication Reminder												

MINNESOTA

Comments: (include Visit Hour)

ONLY IF REQUESTED ON SERVICE PLAN

URINE TEST						VITAL SIGNS					
Time						Time					
	Reading	Reading	Reading	Reading	Reading		Reading	Reading	Reading	Reading	Reading
Type						Temperature					
Color						Pulse					
Odor						Respiration					
Cloudy						BIP					
Not Observed						Blood Sugar					
						Blood Sugar Check					
						Intake					
						Output					
						Enc. 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