PERSONAL CARE ASSISTANCE SERVICE TIME SHEET

Consumer Name: _____

Caregiver Name: _____

Week Ending Date___/____/_20__



	SUN	MON	TUES	WED	THURS	FRI	SAT
TIME IN							
TIME OUT							
HOURS WORKED							
ADL'S: BATHING							
DRESSING							
EATING/FEEDING							
GROOMING							
MOBILITY/WALKING							
TOILET/BOWEL & BLADDER CARE							
TRANSFERRING							
IADL'S: CUEING/REMINDERS FOR SELF-MEDICATION ADMINISTRATION							
HOUSEKEEPING							
LAUNDRY							
MEAL PREP/PLANNING							
SHOPPING							
OTHER: ACCOMPANY TO APPOINTMENTS							
CONVERSATION							
ERRANDS							
TELEPHONE USE							

CAREGIVER SIGNATURE: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DATE: _____

SUPERVISOR SIGNATURE: _____ DATE: _____