

**Compassionate Care at Home Time Sheet- COMPANION USE ONLY**

625 East Main Street, Ste 1, Branford, CT 06405

Phone: (203) 433-7014 Fax: (203) 208-2597

**Client Name:**  
(PLEASE PRINT)

**Employee Name:**  
(PLEASE PRINT)

**Week Ending Date:**

	SAT	SUN	MON	TUE	WED	THU	FRI
<b>DATES:</b>							
<b>TIME IN:</b>	am pm	am pm	am pm	am pm	am pm	am pm	am pm
<b>TIME OUT:</b>	am pm	am pm	am pm	am pm	am pm	am pm	am pm
<b>DAILY TOTAL:</b>							

Supervise Activities							
Escort to Appointments							
Reminder for Medications							
Assist with Communication							
**Other _____							
**Other _____							

<b>CLIENT FULL SIGNATURE</b> (or legal Rep.) (PER SHIFT):							
<b>MILEAGE TOTAL:</b>				<b>WEEKLY TOTAL HOURS:</b>			

**\*\*Client signature authorizes the billing of the above hours and that the hours are accurate. \*\*\*Please do not authorize in advance of service.**

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*Employee's signature certifies that the information regarding hours worked and activities performed is accurate.

**\*\*FOR COMPANION USE ONLY\*\***