Payroll Period: ___/____/____ to ____/____/____

# Visions Healthcare LLC. Personal Care Attendant Timesheet

Employer Name: _____ Attendant Name: _____

| | MON | TUES | WED | THUR | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| **DATES** | / | / | / | / | / | / | / |
| **TIME-IN** | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| **TIME-OUT** | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| **PARTICIPANT INTIALS** | | | | | | | |
| **ATTENDANTS INITIALS** | | | | | | | |
| **TIME-IN** | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| **TIME-OUT** | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| **DAILY TOTAL** | | | | | | | |
| | **HRS MIN** | **HRS MIN** | **HRS MIN** | **HRS MIN** | **HRS MIN** | **HRS MIN** | **HRS MIN** |
| Check box if hospitalized | ☐ Hosp | ☐ Hosp | ☐ Hosp | ☐ Hosp | ☐ Hosp | ☐ Hosp | ☐ Hosp |

| TASKS | MON | TUES | WED | THUR | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| Personal Care | | | | | | | |
| Toileting | | | | | | | |
| Health | | | | | | | |
| Housekeeping | | | | | | | |
| Meal | | | | | | | |
| Transportation | | | | | | | |

Note: Signature verifies that all dates and times entered are true and accurate. I understand that my attendant cannot be paid for time I am in the hospital. Falsification of timesheets is Medicaid Fraud. Visions of St. Louis LLC. procedure is to report all suspected fraud to the Missouri Department of Health and Senior Services. If Fraud is suspected, Your CDS services will be suspended immediately…..TIME SLIPS ARE DUE EVERY MONDAY BY 4 P.M. PLEASE YOU ONE COLOR INK.

Employee Signature: _____ Date: _____

Attendant Signature: _____ Date: _____

**Please Circle One of the following: I Was In The Hospital? YES OR NO I WAS Not In The Hospital? YES OR NO**

**If Hospitalized Please Provide Dates: ____/____/____ to ____/____/____**