AtlantiCare Nursing Services, Inc
CNA & HHA TIMESHEET

Client Name______________________ **Caregiver Name**______________________

(PRINT NAME) (PRINT NAME)

☑ Care Provided	SUN.	MON.	TUE.	WED.	THU.	FRI.	SAT.
DATES							
Personal Hygiene							
Bathing							
Skin Care							
Dressing/Grooming							
Bathroom/Diapers							
Medicine Reminder							
Mobility							
Walking							
Walker/Wheelchair							
Transfer/Hoyer Lift							
Bath Visit							
Safety							
I did not observe any injuries							
Universal Precautions							
Mileage							
Time-In							
Time-Out							
TOTAL							
Client Initials							

Total Weekly Hours ______

CNA/HHA Signature **Date**

Caregiver - By signing above, I hereby certify that all information is correct. I also agree to pay a $4,000 "finders fee" to AtlantiCare Nursing, in the event I elect to work privately for a client of AtlantiCare within 6 months of either the patient or myself discontinuing services and/or association with AtlantiCare Nursing. Finally I agree to a $10 "Late Fee" being assessed if I turn my timesheet in past 9:00 am every Monday morning.

Patient - By signing below, I hereby acknowledge that all information is correct and that I am personally responsible for paying my bill in full each week, regardless as to if AtlantiCare submits the insurance claim on my behalf and takes Assignment of Benefits. I also agree to not solicit and/or have any of AtlantiCare's Caregivers/Contractors work for me for a period of 6 months after services have ended with AtlantiCare; otherwise I will pay AtlantiCare $4,000 in liquidated damages.

Client Signature **Date**

*****Timesheets due every Monday morning by 9:00 Am - Fax (561) 637-4290**