A Better Life
HEALTH CARE NETWORK

**CONSUMER NAME:** _____

**ADDRESS:** _____

**CONSUMER PHONE:** _____

**ATTENDANT NAME:** _____ **ATTENDANT PHONE :** _____

| FILL IN DATE HERE | TIME IN | TIME OUT | TOTAL HOURS | ATTENDANT SIGNATURE | EMPLOYER SIGNATURE | X here if in hospital |
|---|---|---|---|---|---|---|
| SATURDAY | | | | | | |
| SUNDAY | | | | | | |
| MONDAY | | | | | | |
| TUESDAY | | | | | | |
| WEDNESDAY | | | | | | |
| THURSDAY | | | | | | |
| FRIDAY | | | | | | |

**TOTAL HOURS:** _____ **TOTAL HOURS APPROVED:** _____ **(OFFICE USE)**

| CHORES: | SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY |
|---|---|---|---|---|---|---|---|
| PERSONAL CARE | | | | | | | |
| TOILETING | | | | | | | |
| HEALTH | | | | | | | |
| HOUSEKEEPING | | | | | | | |
| MEALS | | | | | | | |
| TRANSPORTATION | | | | | | | |

**PLEASE CHECK SERVICES RENDERED EACH DAY:**

DATES MUST HAVE **MONTH, DAY, & YEAR**. NOTE **AM or PM** ON YOUR IN AND OUT TIMES. USE SAME PEN, **BLACK INK ONLY. NO WHITE-OUT** IS ALLOWED. TURN IN TIME SHEETS **WEEKLY** TO ENSURE TIMELY PROCESSING OF YOUR PAYCHECK. CONSUMER AND ATTENDANTS MUST SIGN HIS OR HER OWN NAME. FRAUD WILL BE NOTIFIED TO THE MO HEALTH AND SENIOR SERVICES DEPARTMENT.

**A BETTER LIFE HEALTH CARE NETWORK**

**3501 Dunn Rd. Florissant, MO 63033 Phone: 314-266-0289 Fax: 314-972-1400**