All highlighted Areas must be filled out

abetterlife
Health Care Network

Consumer Name: _____

Address: _____

Consumer Phone Number: _____

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 APPROVED HOURS: (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, AND YEAR.** NOTE **AM** OR **PM** ON YOUR IN AND OUT TIMES. USE SAME PEN, **BLACK INK ONLY. NO WHITE OUT IS ALLOWED.** TURN IN TIMESHEETS **WEEKLY** TO ENSURE TIMELY PROCESSING OF YOUR PAYCHECK. CONSUMER AND ATTENDANTS MUST SIGN THEIR OWN NAME. FRAUD WILL BE NOTIFIED TO THE MISSOURI HEALTH AND SENIOR SERVICES DEPARTMENT.

A BETTER LIFE HEALTH CARE NETWORK
3533 DUNN ROAD SUITE 230 FLORISSANT, MO 63033 PHONE: 314-266-0289 FAX: 314-972-1400

abetterlife
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