

## Bridgeway Home Healthcare Service

3300 County Road 10 | Suite 120D | Brooklyn Center, MN 55429  
Payroll (612) 216-4666 | Email: support@bridgewayhomehealthcare.com

**Week Ending Date: (Always Saturday )**

Employee Name: (Please Print)	
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Month (MM)	Day (DD)	Year (YY)

Client Name: (Please Print)	
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	SUN	MON	TUES	WED	THURS	FRI	SAT
DATES							

### Visit One

TIME IN							
TIME OUT							

### Visit Two

TIME IN							
TIME OUT							

DAILY TOTAL							
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Please initial next to each activity you completed. Only initial the tasks you personally performed.

Individualized Home Support							
Community Participation							
Household Management							
Homemaker							
Cleaning / Laundry/ Meal Prep.							
Shopping / Errands							
Companion							
Supervision and Socialization							
Respite							
Supervision and Care							
Night Supervision							
Overnight assistance and Supervision							
Other							
Task:							
Task:							

**WEEKLY HOUR TOTAL:**

CLIENT'S FULL SIGNATURE (or Legal Rep.)	
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Signature of Client or representative confirms the above hours are accurate, ratifies all terms of the written ISA received by client, and authorizes billing under said terms.  
Do not authorize in advance of service.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_