

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)	
----------------------------------	--

Month (MM)	Day (DD)	Year (YY)

Client Name: (Please Print)	
--------------------------------	--

	SUN	MON	TUES	WED	THURS	FRI	SAT
DATES →							
TIME IN							
TIME OUT							
DAILY TOTAL							

	SUN	MON	TUES	WED	THURS	FRI	SAT
Individualized Home Support							
Community Participation							
Health, Safety, Wellness							
Household Management							
HOMEMAKER							
Cleaning / Laundry							
Shopping / Errands							
Meal Prep. / Clean-up							
COMPANION							
Supervise Activities							
Escort to Appointments							
Medication reminders							
OTHER							
Task _____							
Task _____							

MILEAGE TOTAL:	WEEKLY HOUR TOTAL:
-----------------------	---------------------------

CLIENT'S FULL SIGNATURE (or Legal Rep.)	
---	--

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: _____