CAREGIVER WEEKLY TIMESHEET

Return Forms to:
SHIP
PO Box 64913
St. Paul, MN 55164-0913

Insured:

Policy Number:

CAREGIVER INSTRUCTIONS

1. Complete a new timesheet each week.
2. Indicate in EVERY box EACH day the level of assistance provided ON THAT DAY using the Charting Key to the right.
3. Enter the start & end times, number of hours worked, and total pay EVERY day along with a weekly total pay at the end.
4. Write a daily note describing the insured's care needs, problems, appointments, important events, or change in condition.
5. Print your name, relationship to insured, sign, and date the completed form

CHARTING KEY
X = Not done today
I = Insured performed task Independently
S = Supervise/ Standby Assist within arm's reach
A =Hands-on Assistance required to complete task

Activity Date	Reimbursement Rate $____/ Hour or Day	Feed	Bath	Dress	Toilet / Continent	Walk / WC	Transfer	Meds	Meal Prep	Clean & Laundry	Shop & Transport
Monday	Time In										
__/___/___	Time Out	Daily Note									
	Total # Hrs										
	Mon Pay $										
Tuesday	Time In										
__/___/___	Time Out	Daily Note									
	Total # Hrs										
	Tues Pay $										
Wednesday	Time In										
__/___/___	Time Out	Daily Note									
	Total # Hrs										
	Wed Pay $										
Thursday	Time In										
__/___/___	Time Out	Daily Note									
	Total # Hrs										
	Thurs Pay $										
Friday	Time In										
__/___/___	Time Out	Daily Note									
	Total # Hrs										
	Fri Pay $										
Saturday	Time In										
__/___/___	Time Out	Daily Note									
	Total # Hrs										
	Sat Pay $										
Sunday	Time In										
__/___/___	Time Out	Daily Note									
	Total # Hrs										
	Sun Pay $										

TOTAL WEEKLY PAY **$**_____ Caregiver relationship to Insured: _____ Caregiver SSN#:_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Print Caregiver Name _____ Signature _____ Date_____

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INSURED / REPRESENTATIVE INSTRUCTIONS:

1. Verify the accuracy of the services provided and reimbursement information above.
2. Complete the form with your name, date, and signature.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Print Insured / Legal Representative Name _____ Signature _____ Date _____

If you have any questions, please call 877-450-5824