8500 Menaul NE
B290
Albuquerque, NM 87112
Ph: (505) 888-9618 Fax: (505) 883-2931

ST ANTHONY'S HOME HEALTHCARE SERVICES, LLC

☐ DIRECT CARE CLIENT
☐ DELEGATED CLIENT

1930 Main Street
Suite 8
Los Lunas, NM 87031
Ph: (505) 865-6128 Fax: (505) 865-7033

TIME CLOCK CORRECTION FORM . You must still Clock in to the Authenticare system.
THIS DOES NOT REPLACE THE CLOCK IN SYSTEM.

Personal Care Timesheet Dates: From ***SUNDAY*** _____ To ***SATURDAY*** _____

CLIENT INFORMATION	**CAREGIVER INFORMATION**
Client Name	**Caregiver Name** Phone:

ACCEPTABLE CORRECTION CODES

A. Tablet malfunction. Notify Office within 24 hours. Weekends are the only exception
B. Smartphone Malfunction. Include Reference # from call to Provider (eg Verizon, Cricket)
C. Landline temporarily unavailable. Reference # from call to your provider
D. Tablet not received prior to start of services. (Office staff will include order date and expected delivery date)
E. Inclement weather, and caregiver unable to upload check-ins within 7 days. (Office staff will get weather report)
F. Electrical outage NOT due to inclement weather
G. Authorization Issue (Copy of email to MCO)

Check All that Apply

	Date MM/DD/YY	TIME In	TIME OUT	TOTAL HRS	1.Hygiene	2. Bowel & Bladder	3.Meal Prep	4.Eating	5. Household Support	6. Mobility	7. Hauling Water	8. Suppor Services	Reason for Missed Punch
Sunday					☐	☐	☐	☐	☐	☐	☐	☐	
Monday					☐	☐	☐	☐	☐	☐	☐	☐	
Tuesday					☐	☐	☐	☐	☐	☐	☐	☐	
Wednesday					☐	☐	☐	☐	☐	☐	☐	☐	
Thursday					☐	☐	☐	☐	☐	☐	☐	☐	
Friday					☐	☐	☐	☐	☐	☐	☐	☐	
Saturday					☐	☐	☐	☐	☐	☐	☐	☐	

Consumer Signature:	**Caregiver Signature:**
By signing this sheet, I hereby certify that I received these services. I understand that signing this time sheet if I did not receive these services can be considered Medicaid Fraud.	By signing this sheet, I hereby certify that I provided these services, I understand that signing this sheet if I did not provide these services can be considered Medicaid Fraud.
_____ _____ **Signature of Client/Legal Rep.** **Date**	_____ _____ **Signature of Homemaker** **Date**