Office: 561-740-8667
Fax: 561-880-0317
Fax: 561-572-9178
1014 Gateway Blvd, Ste. 101
Boynton Beach, FL 33426
timesheets@auracalshc.com

CNA & HHA INVOICE

Independent Contractor

Client Name: _____ (Print Name) **Name:** _____ (Print Name)

☑ Care Provided	Date	Sun.	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.
Personal Hygiene								
Bathing / Shower								
Skin Care								
Dressing / Grooming								
Toileting / Diapers								
Assist with Feeding								
Mobility								
Walking / Ambulation Assist								
Walker / Wheelchair								
Transfer / Hoyer Lift								
Reposition								
Medication Reminder								
Assist with Medication								
Safety								
Universal Precautions								
Fall Prevention								
I did not observe any injuries								
Bath Visit								
Mileage								
Time-In								
Time-Out								
	Total							
	Client Initials							

Total Weekly Hours: _____

Independent Contractor - By signing below, I hereby certify that all information is correct.

Client - By signing below, I hereby acknowledge that all information is correct and that I am personally responsible for paying my bill in full each week, regardless as to if Auracal Senior Home Care, LLC submits the insurance claim on my behalf and takes Assignment of Benefits.

Independent Contractor Signature **Date** **Client Signature** **Date**

Please submit to Auracal Monday morning by 9:00am - Fax: 561-880-0317 OR 561-572-9178 EMAIL: timesheets@auracalshc.com