
Time and Activity Documentation Personal Support, Respite, Companion

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| Week 1 | THU | FRI | SAT | SUN | MON | TUE | WED | Week 2 | THU | FRI | SAT | SUN | MON | TUE | WED |
| Month/Day/Year |  |  |  |  |  |  |  | Monthly/day/year |  |  |  |  |  |  |  |
| Time In Am/Pm |  |  |  |  |  |  |  | Time In |  |  |  |  |  |  |  |
| Time Out Am/Pm |  |  |  |  |  |  |  | Time Out |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Total Daily Hrs: |  |  |  |  |  |  |  | Total Daily Hrs: |  |  |  |  |  |  |  |
| Supports |  |  |  | Supports |  |   |  |
| Dressing |  |  |  |  |  |  |  | Dressing |  |  |  |  |  |  |  |
| Grooming |  |  |  |  |  |  |  | Grooming |  |  |  |  |  |  |  |
| Bathing |  |  |  |  |  |  |  | Bathing |  |  |  |  |  |  |  |
| Eating |  |  |  |  |  |  |  | Eating |  |  |  |  |  |  |  |
| Transfers |  |  |  |  |  |  |  | Transfers |  |  |  |  |  |  |  |
| Mobility |  |  |  |  |  |  |  | Mobility |  |  |  |  |  |  |  |
| Positioning |  |  |  |  |  |  |  | Positioning |  |  |  |  |  |  |  |
| Toileting |  |  |  |  |  |  |  | Toileting |  |  |  |  |  |  |  |
| Health-Related |  |  |  |  |  |  |  | Health-Related |  |  |  |  |  |  |  |
| Behavior |  |  |  |  |  |  |  | Behavior |  |  |  |  |  |  |  |
|  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other outings |  |  |  |  |  |  |  | Other outings |  |  |  |  |  |  |  |

Acknowledgement and Required Signatures: After the Caregiver documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from and the Review the completed timesheet for accuracy before signing. It is a federal crime to provide false information on Caregivers billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the Caregiver care plan.

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| Note: All times (Dates/Times) of client stay in Hospital, Care Facility, or Incarceration are NOT counted as caregiver service hours, and therefore are NOT billable. |

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| Print Name:  | Provider  | Please use standard 12 hr time and indicate AM and PM. |
| Signature: | Date: |
| Print Client Name:  | MA # or DOB:  | OFFICE USE ONLY |
| Client or Responsible Party Signature: | Date: | Two Week Total: |

Caregiver Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Is there change of address of Caregiver or Client address? \_\_\_\_\_\_\_ . If yes, please update address below.