

Dates/Location of recipient stay in hospital/care facility/incarceration														
Dates of Service MM/DD/YY (month/day/year)	Week 1 SUN 9/4/16	MON 9/5/16	TUE 9/6/16	WED 9/7/16	THUR 9/8/16	FRI 9/9/16	SAT 9/10/16	Week 2 SUN 9/11/16	MON 9/12/16	TUE 9/13/16	WED 9/14/16	THUR 9/15/16	FRI 9/16/16	SAT 9/17/16
Activities (initial each box in which supports were provided by you for each shift)														
Dressing														
Grooming														
Bathing														
Eating														
Transfers														
Mobility														
Positioning														
Toileting														
Health Related														
Behavior														
IADL's														
Homemaking			1.5			1.5			1.5				1.5	
Visit One														
Time in (circle AM/PM)		AM PM	AM PM	10:45 AM PM	AM PM	AM PM	11:30 AM PM	AM PM	AM PM	10:30 AM PM	AM PM	AM PM	AM PM	8:00 AM PM
Time out (circle AM/PM)		AM PM	AM PM	1:15 AM PM	AM PM	AM PM	2:15 AM PM	AM PM	AM PM	11:45 AM PM	AM PM	AM PM	AM PM	10:00 AM PM
Visit Two														
Time in (circle AM/PM)		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	4:00 AM PM	AM PM	AM PM	AM PM	AM PM
Time out (circle AM/PM)		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	6:00 AM PM	AM PM	AM PM	AM PM	AM PM
Daily Total (Hours)	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours
			2.5			2.75			3.25				2	
Total Hours (This time sheet)	Total Hours 10.5													
Acknowledgement and Required Signatures														
After the Homemaker / Respite / DSP has documented his/her time and activity, the recipient must draw a line through any dates/times he/she did not receive services from the Homemaker / Respite / DSP. Review the completed contact sheet for accuracy before signing. It is a crime to provide false information on Homemaker / Respite / DSP billings for Medical Assistance payment. By signing below you swear and verify the time and services entered above are accurate and that the services were performed by the Homemaker / Respite / DSP listed below as specified in the Homemaker / Respite / DSP Care Plan.														
Consumer / RP Name (print) John Smith					Consumer / RP Signature <i>John Smith</i>					Date 9/17/16				
I certify and swear under penalty of law that I have accurately reported on this time sheet the hours I actually worked, the services I provided, and the dates and times worked. I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings.														
Homemaker / Respite / DSP Name (print) Jane Smith					Homemaker / Respite / DSP Signature <i>Jane Smith</i>					Date 9/17/16				