Night Supervision Time and Activity Documentation

Employee Name _____

AbbeyCare, Inc. 1148 Grand Ave St. Paul, MN 55105 **651-690-5352** **www.abbeycareinc.com**

Duties	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Compainionship/Social Stimulation														
Meal Preparation														
Assistance with Activities of Daily Living														
Monitor Safety/Well Being														
Positive Support														
Conversation/Read														
Other														

DAY OF THE WEEK	**DATE**	**Time In** (Circle AM/PM)	**Time Out** (Circle AM/PM)	**Daily Total**
MONDAY		AM PM	AM PM	
TUESDAY		AM PM	AM PM	
WEDNESDAY		AM PM	AM PM	
THURSDAY		AM PM	AM PM	
FRIDAY		AM PM	AM PM	
SATURDAY		AM PM	AM PM	
SUNDAY		AM PM	AM PM	
MONDAY		AM PM	AM PM	
TUESDAY		AM PM	AM PM	
WEDNESDAY		AM PM	AM PM	
THURSDAY		AM PM	AM PM	
FRIDAY		AM PM	AM PM	
SATURDAY		AM PM	AM PM	
SUNDAY		AM PM	AM PM	
			TOTAL	

Acknowledgement and Required Signatures

After the employee has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the employee. Review the completed time sheet for accuracy before signing. ***It is a federal crime*** *to provide false information on 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 Care Plan.*

CLIENT NAME (First, MI, Last)	MA MEMBER # OR DOB	EMPLOYEE NAME (First, MI, Last)	
CLIENT / RESPONSIBLE PARTY SIGNATURE	DATE	EMPLOYEE SIGNATURE	DATE

Employee's Current Phone Number:_____