Companion Time and Activity Documentation

Companion Name ___________________________________

Days of Service	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Companionship/Social Stimulation														
Meal Preparation														
Assistance with Activities of Daily Living														
Monitor the Safety and Well Being														

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 Companion 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 Companion. 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	COMPANION NAME (First, MI, Last)	
CLIENT / RESPONSIBLE PARTY SIGNATURE	DATE	COMPANION SIGNATURE	DATE

Companion's Current Phone Number:________________________________