Individual Community Living Support Documentation

Employee Name ____

Days of Service	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Assist with Problem Solving														
Assist with Daily Living Skills														
Assist with Budget and Money Management														
Assist with Communication														
Assist with Medication														
Assist with Exercises/ Other Health Management														
Maintenance of Medical Equipment/Adaptive Technology														
Assist with Community Engagement														
Cleaning/Household Services/Meal Preparation/Errands/Grocery Shopping														
Monitor Health, Safety and Wellness														
Remote Assistance (Must be Prior Authorized)														
Observing and Redirecting Behavior/Orientation/ Cognitive Support														

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: ____________________________