



IHS (Individualized Home Supports without training) 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
Companionship/Social Stimulation														
Meal Preparation/Household Management														
Assistance with Activities of Daily Living														
Monitor Safety/Well Being/Crisis prevention skills														
Accessing community services/Connections to community														
Accompany to Appointments														
Assist with Phone Calls/Communication														
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: _____