COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS)

CFSS Worker Time and Activity Documentation

Covered activities Check for each covered activity under the date indicated.

Activities	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Dressing														
Grooming/Bathing														
Eating														
Transfers														
Mobility														
Positioning														
Toileting														
Health Related														
Behaviors														
IADLs														
Other:														

Dates/Location of Person's stay in Hospital/Care Facility/Incarceration (if known)

Date From: **Date To:**

Overtime (over 40 hours per week) must have prior authorization from AbbeyCare.

Visit details For each day noted above, provide visit details. **Only enter dates you provided services**.

Date MM/DD/YY	Visit 1 Time in (hh:mm am/pm)	Time out (hh:mm am/pm)	Visit 2 Time in (hh:mm am/pm)	Time out (hh:mm am/pm	Total Time (covered activities)	Total other: (i.e., training, performance evaluation)
Mon	am pm	am pm	am pm	am pm		
Tue	am pm	am pm	am pm	am pm		
Wed	am pm	am pm	am pm	am pm		
Thu	am pm	am pm	am pm	am pm		
Fri	am pm	am pm	am pm	am pm		
Sat	am pm	am pm	am pm	am pm		
Sun	am pm	am pm	am pm	am pm		
Mon	am pm	am pm	am pm	am pm		
Tue	am pm	am pm	am pm	am pm		
Wed	am pm	am pm	am pm	am pm		
Thu	am pm	am pm	am pm	am pm		
Fri	am pm	am pm	am pm	am pm		
Sat	am pm	am pm	am pm	am pm		
Sun	am pm	am pm	am pm	am pm		

CFSS worker's signature

Total Hours:_____

I declare under penalty of perjury that all hours worked and descriptions of work performed contained in the submitted shifts are true and correct with full knowledge that all of this information may be subject to investigation and that any false or dishonest information contained on these shifts may be grounds for denial of payment and/or reporting of findings to the investigation unit of the Department of Human Services.

First Name	MI	Last Name	UMPI Number	Signature	Date Signed

Person's/Participant Representative signature

Review for accuracy before signing. It is a crime to provide false information on billings for Medical Assistance payments. By signing you swear and verify the time/services entered are accurate and that services were performed by the worker listed below as specified in the person's plan.

Person's First Name	MI	Last Name	DOB	Person/Participant Representative Signature	Date Signed

AbbeyCare Choice, Inc. 1148 Grand Ave St. Paul, MN 55105 (ph) 651-690-5352 (f) 651-209-8065

www.abbeycareinc.com email: pcatimecards@abbeycareinc.com

CFSS Worker phone _____ email: _____

Instructions to complete CFSS Time and Activity Documentation form

This form documents the time and activity between one CFSS worker and one person who uses CFSS. Employers may have additional instructions or documentation requirements. For shared care, you must use a separate form for each person you provide care to.

Person using CFSS stays (if known)
Enter dates and location a person stays in a hospital, care facility or incarceration, if known.

Dates of service
The service must be in consecutive order. Enter the date in mm/dd/yy format for each date you provide services. Do not enter dates you did not provide services on.

Activities
For each date you provided care, check the box. The following are general descriptions of activities of activities of daily living:

- **Dressing**: Choosing appropriate clothing for the day, includes laying out of clothing, actual applying and changing clothing, special appliances or wraps, transfers, mobility and positioning to complete this task.
- **Grooming**: Personal hygiene, which includes basic hair care, oral care, nail care (except people who are diabetic or have poor circulation), shaving hair, applying cosmetics and deodorant, care of eyeglasses, contact lenses, hearing aids.
- **Bathing**: Starting and finishing a bath or shower, transfers, mobility, positioning, using soap, rinsing, drying, inspecting skin and applying lotion.
- **Eating**: Getting food into the body, including hand washing, applying orthotics needed for eating, feeding.
- **Transfers**: Moving from one seated/reclining area or position to another.
- **Mobility**: Moving including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a person.
- **Positioning**: Including assistance with positioning or turning a person for necessary care and comfort.
- **Toileting**: Bowel/bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspecting skin and adjusting clothing.
- **Health-related procedures and tasks**: Activities listed on the service delivery plan and considered within the scope of CFSS services that meet the definition of health-related procedures and tasks, such as: Range of motion and passive exercise, assistance with self-administered medication (including bringing medication to the person and assistance with opening medication under the direction of the person/responsible party), interventions, monitoring/observations for seizure disorders and others.
- **Behavior**: Redirecting, intervening, observing, monitoring and documenting behavior.
- **IADLs (instrumental activities of daily living)**: Activities related to living independently in the community, including but not limited to: Meal planning/preparation, shopping, laundry, housecleaning, managing finances, communicating needs and preferences during activities, driving.
- **Skills (acquisition, enhancement and maintenance)**: If you assisted someone with skills, select activity they were learning/maintaining.

Visit
To document more than 2 visits on the same day, use a new form for each visit.

Shared service
Ratio of worker to person
1:2= One CFSS worker to two people (shared service)
1:3= One CFSS worker to three people (shared service)
Must be prior authorized.
Use "Shared CFSS Worker Time and Activity" documentation

Time in
Enter time in hours and minutes that you started providing care. If you use military time, it automatically will assign the a.m. or p.m. designation.

Time out
Enter time in the hours and minutes that you stopped providing care. If you use military time, it automatically will assign the a.m. or p.m. designation.

Daily total
Add the total time that you spent with this person for the care documented in each day's row. Then, enter the total time you worked providing covered services in first column. In the second column, enter the time you worked while doing other employer-required activities (e.g. training, performance evaluation, etc). If you are unsure if a task is covered or another employer-required activity, ask your provider agency

Total time this time sheet
Add the time for all visits on this entire time sheet and enter the total in the appropriate ratio box.

- **Use "Total other" to record training/performance evaluation time only.**

Acknowledgment and required signatures
Both the CFSS worker and the person (or their participant's representative) must complete all fields in their section. **All signatures must be physical/ handwritten/made in ink on the document. E-signatures will not be accepted for processing.**