



Easter Seals TIME SHEET - SUPPORTING DOCUMENTATION

Consumer Name: (please print)	Week End Date:	Case #
Provider Name: (Please print)	Service Code(s): <input type="checkbox"/> Respite Care TT1005; CLS H2015	

FOR EACH CLS SHIFT PLEASE PLACE A CHECK MARK INDICATING THE SERVICE YOU PROVIDED AND WHICH DAY IT WAS PERFORMED. THESE SHOULD REFLECT THE GOALS IN THE PLAN OF SERVICE.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Remind, Observe, Train & Support							
Food Preparation							
Laundry							
Routine Household Care							
Activities of Daily Living							
Shopping							
Money Management							
Socialization/Relationship Building							
Leisure Choice/ Participation in Community Activities							
Medical Appointment Attendances							
Transportation to Community Activity:							
Monitor & Protection of Health and Safety							
Non-Medical Care							
Monitor Self Administration of Medication							

REQUIRED: FOR EACH SHIFT WORKED (RESPIRE/CLS) PLEASE NOTE WHAT WAS DONE AND ANY CONCERNS OR OBSERVATIONS YOU HAVE.

Date:	Location(s): Home <input type="checkbox"/> Community <input type="checkbox"/>	CLS time In and Out	to	Respite time In and Out	Caregiver Signature:
Notes:					
Date:	Location(s): Home <input type="checkbox"/> Community <input type="checkbox"/>	CLS time In and Out	to	Respite time In and Out	Caregiver Signature:
Notes:					
Date:	Location(s): Home <input type="checkbox"/> Community <input type="checkbox"/>	CLS time In and Out	to	Respite time In and Out	Caregiver Signature:
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Notes:					
Date:	Location(s): Home <input type="checkbox"/> Community <input type="checkbox"/>	CLS time In and Out	to	Respite time In and Out	Caregiver Signature:
Notes:					

IMPORTANT - A COMPLETED TIMESHEET INCLUDES BOTH PAGE 1 AND 2 FILLED OUT IN ENTIRETY WITH AN AUTHORIZED SIGNATURE!



Easter Seals TIMESHEET -- TIME IN/TIME OUT

I understand as a condition of my employment, I must adhere to the scheduled hours allocated to the consumer for whom I provide care. In the event a budget is modified, ExpertCare Management Services is the only party that can authorize a change in your employee work schedule. Violation of this policy will result in disciplinary action up to and including termination. Provider: Please fill in completely. Keep a copy for yourself. The ExpertCare copy of the completed time card must be received in our office by 8:00am on Monday, regardless of a holiday. Failure to turn in your timesheet by the deadline will result in delay of pay until the next pay date.

Week Ending	Consumer (Please Print)	Provider (Please Print)

Date	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Week Total
CLS Time In								
CLS Time Out								
CLS Total								
Respite Time In								
Respite Time Out								
Respite Total								
Per Diem Time In								
Per Diem Time Out								
Per Diem Total								

Please indicate if hours worked are CLS, Respite or Per Diem by completing the box aligned with the service you performed. Specify 2:1 care if applicable.

I attest, under the penalty of perjury, I have worked the hours declared above and they are true, correct and compliant with Federal and State Funds. Signatures are not to be copied from a previous timesheet and must be the original signatures. Consumers, by signing this timesheet, you attest that all information is accurate. No whiteout or pre-signed timesheets will be accepted. Timesheets must reflect actual hours worked.

Provider's Signature: _____

Last 4 digits of social security: _____

Authorized Consumer Signature: _____

IMPORTANT - A COMPLETED TIMESHEET INCLUDES BOTH PAGE 1 AND 2 FILLED OUT IN ENTIRETY WITH AN AUTHORIZED SIGNATURE!

IT IS A REQUIREMENT THAT CLS AND RESPITE HOURS BE DOCUMENTED AGAINST THE GOALS IN THE PLAN OF SERVICE. ANY QUESTIONS PLEASE CALL 1-866-812-8896

If you would like to verify receipt of timesheet please leave a message in the payroll mailbox: 248-205-7205 Payroll will return the call on Monday if there is a problem or if the timesheet was not received.