

**Consumer Directed Services**

**Timesheet**

Independent Living Center

Your “Access II” disABILITY Resources

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Month / Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **TIME IN: AM / PM** Consumer Initials \_\_\_\_\_\_\_ Attendant Initials \_\_\_\_\_\_\_  **TIME OUT: AM / PM** Consumer Initials \_\_\_\_\_\_\_ Attendant Initials \_\_\_\_\_\_\_  **Total Hours / Minutes Worked**  **100- CDS Personal Care  *\*\*Check Mark All Authorized Tasks Completed\*\**** | | | | | | | | |
| **Tasks** | **Did you Provide** | | **Tasks** | **Did you Provide** | | **Tasks** | **Did you Provide** | |
| Dressing/Grooming | YES | NO | Turning / Positioning | YES | NO | Laundry ( Home ) | YES | NO |
| Bathing | YES | NO | Mobility / Transfer | YES | NO | Laundry ( Off Site ) | YES | NO |
| Ostomy Hygiene | YES | NO | Treatments | YES | NO | Trash | YES | NO |
| Catheter Hygiene | YES | NO | Clean / Maintain Equipment | YES | NO | Essential Correspondence | YES | NO |
| Bowel / Bladder Routine | YES | NO | Clean Bath | YES | NO | Meal Preparation / Eating | YES | NO |
| Assist with Toileting | YES | NO | Make Bed | YES | NO | Wash Dishes | YES | NO |
| Assist with Transfer Device | YES | NO | Change Linens | YES | NO | Clean Kitchen | YES | NO |
| Passive Range of Motion (ROM) | YES | NO | Clean Floors | YES | NO | Essential Transportation | YES | NO |
| Medications | YES | NO | Tidy and Dust | YES | NO |  |  |  |

Timesheets are ONLY to be completed when you are unable to use the telephony system.

The Consumer/Employer must immediately contact Access II **PRIOR** to submitting a timesheet.

All paper timesheets must be submitted to Access II no later than **Monday at NOON** **on a payroll week**.

Any falsification or other misrepresentation on time worked will constitute Medicaid Fraud. All payments made as a result of

Inaccurate time worked/logged will be recouped from the Consumer/Employer and the Employee/Attendant.

In addition, any apparent Medicaid Fraud will be reported to the proper authorities.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer/Employer Signature Required Employee Signature Required