CFSS TIME AND ACTIVITY DOCUMENTATION

HMONG HOME HEALTH CARE, LLC. **Ph: 651-488-1680** **Fax: 651-488-4087**

DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION:

DATES OF SERVICE (in consecutive order)	**MON** (MM/DD/YY)	**TUE** (MM/DD/YY)	**WED** (MM/DD/YY)	**THU** (MM/DD/YY)	**FRI** (MM/DD/YY)	**SAT** (MM/DD/YY)	**SUN** (MM/DD/YY)

	MON (MM/DD/YY)	**TUE** (MM/DD/YY)	**WED** (MM/DD/YY)	**THU** (MM/DD/YY)	**FRI** (MM/DD/YY)	**SAT** (MM/DD/YY)	**SUN** (MM/DD/YY)

ACTIVITIES	**WEEK 1**						
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
IADLs							

	WEEK 2						
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
IADLs							

VISIT ONE

Ratio staff to recipient	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3
Shared services location							
Time In (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Ratio staff to recipient	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3
Shared services location							
Time In (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

VISIT TWO

Ratio staff to recipient	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3
Shared services location							
Time In (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Ratio staff to recipient	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3
Shared services location							
Time In (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Daily Total (Minutes)							
	Total 1:1		**Total 1:2**		**Total 1:3**		
Total Minutes (Minutes)							

Total 1:1	**Total 1:2**	**Total 1:3**	

ACKNOWLEDGEMENT AND REQUIRED SIGNATURES: After the support worker has documented his/her time and activity, the participant must draw a line through any dates/times he/she did not receive services from the support worker. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on CFSS 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 CFSS Service Delivery Plan.

PARTICIPANT NAME (FIRST, MI, LAST)	MA MEMBER # or DATE OF BIRTH	PARTICIPANT/PARTICIPANT'S REPRESENTATIVE SIGNATURE	DATE
SUPPORT WORKER (FIRST, MI, LAST)	SUPPORT WORKER NPI/UMPI	SUPPORT WORKER SIGNATURE	DATE

Please use BLACK ink only. White out is not permitted on this form.