ALL KARE ALTERNATIVE, INC.

WEEKLY TIME SHEETS FOR WEEK BEGINNING_____ _____/_____/_____ ENDING_____/_____/_____

STAFF NAME_____CLIENT'S NAME_____

DATE	DAY	TIME IN A.M	TIME OUT A.M.	TIME IN P.M.	TIME OUT P.M.	TOTAL HOURS
	SUNDAY					
	MONDAY					
	TUESDAY					
	WEDNESDAY					
	THURSDAY					
	FRIDAY					
	SATURDAY					

TOTAL HOURS FOR WEEK_____

SIGNATURE OF STAFF_____DATE_____

SIGNATURE OF CLIENT/REPRESENTATIVE_____DATE_____

LOG OF WEEKLY SERVICES/SUPPORTS and DAILY PROGRESS NOTES for COMMUNITY CHOICES WAIVER – PAS – SINGLE EMPLOYEE

PROVIDER AGENCY NAME: ALL KARE ALTERNATIVE, INC.

RECIPIENT NAME:

DIRECT SERVICE WORKER'S NAME:

Week Of: Through:

RECIPIENT DOB:

Day Of Week:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date→							
1st Arrival Time W/ Initials→							
1st Departure Time W/ Initials→							
2nd Arrival Time W/ Initials→							
2nd Departure Time W/ Initials→							

↓ Indicate Task Completed Each Day W/Initials in Column for the Type PAS provided ↓

↓ Tasks ↓	FOR 1	FOR 2	FOR 3	AM	PM	FOR 1	FOR 2	FOR 3	AM	PM	FOR 1	FOR 2	FOR 3	AM	PM	FOR 1	FOR 2	FOR 3	AM	PM	FOR 1	FOR 2	FOR 3	AM	PM	FOR 1	FOR 2	FOR 3	AM	PM	FOR 1	FOR 2	FOR 3	AM	PM
Eating																																		
Bathing																																		
Dressing																																		
Grooming																																		
Transferring																																		
Ambulation																																		
Toileting																																		
Light Housekeeping																																		
Food Preparation & Storage																																		
Shopping																																		
Laundry																																		
Medication Reminders																																		
Assist To Sched Med Appts																																		
Assist To Arrange Med Trans																																		
Accompany To Med Appts																																		
Protective Supervision																																		
Supv/Assit W/Health Tasks																																		
Escort for Assist W/Comm Tasks																																		
Extension of Therapy Services																																		
Daily Total # Of Hours →																																		

WEEKLY TOTAL # of Hours→ WEEKLY PAS for 1: _____ HOURS WEEKLY PAS for 2: _____ HOURS WEEKLY PAS for 3: _____ HOURS WEEKLY PAS AM_____ WEEKLY PAS PM_____

RECIPIENT/DESIGNATED RESPONSIBLE REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): _____

NOTE: DAILY SERVICES/SUPPORTS DESCRIPTIONS, COMMENTS AND PROGRESS NOTES ARE TO BE RECORDED ON PAGE 2 OF THIS FORM. ADDITIONAL PAGES MAY BE USED.

Effective October 1, 2011

PROVIDER AGENCY NAME: ALL KARE ALTERNATIVE, INC.	DIRECT SERVICE WORKER's NAME:
RECIPIENT NAME:	RECIPIENT DOB:
WEEK OF:	THROUGH:

DAILY SERVICES/SUPPORTS DESCRIPTIONS AND COMMENTS:

DAY OF WEEK AND DATE ↓	DESCRIPTIONS AND COMMENTS ↓

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____

DSW SUPERVISOR's REVIEW SIGNATURE & DATE (Use of this line is optional): _____

PROVIDER AGENCY NAME: ALL KARE ALTERNATIVE, INC.	DIRECT SERVICE WORKER's NAME:
RECIPIENT NAME:	RECIPIENT DOB:
WEEK OF:	THROUGH:

DAILY SERVICES/SUPPORTS DESCRIPTIONS AND COMMENTS:

DAY OF WEEK AND DATE ↓	DESCRIPTIONS AND COMMENTS ↓

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____

DSW SUPERVISOR's REVIEW SIGNATURE & DATE (Use of this line is optional): _____