

**Medicaid Home and Community-Based Services Waiver Programs
Caregiver Time Sheet/Caregiver Service Record Form**

Waiver Program: Waiver for Older Adults (WOA) Living at Home Waiver (LAH)

Waiver Participant Name (Print) _____

Caregiver (Attendant/Personal Care) Name (Print) _____

Check applicable box: Provider Type: Independent Agency _____
(Name)

Day	Date of Service	Start Time	Stop Time	Start Time	Stop Time	Total Hours	Participant Initials
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							

Participant's/ Representative's Signature _____

Date _____

Provider's Signature _____

Date _____

By signing above, the caregiver certifies the services rendered are in accordance with the authorized Plan of Service/Plan of Care on the above dates of service as specified in the Caregiver Service Plan and that the caregiver delivered to the participant all service hours listed on this form.

Write "YES" or "NO" in the boxes next to the task to show what you did on each day

Task	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Comment
Personal Hygiene (i.e. bathing, hair, oral, nail, and skin care)								
Toileting (i.e. bladder, bowel, and bed pan routines; movement to/from bathroom)								
Dressing & Changing Clothes								
Mobility & Transfers								
Eating & Drinking								
Medications								
Light Housekeeping (e.g. Laundry)								
Errands								
Other (please specify):								

Independent caregiver – Attach the white copy of this signed timesheet to the appropriate program billing form. (LAH - DHMH 4660 or WOA - CMS 1500) Submit the forms for payment.

Agency caregiver – Submit the white copy of this signed time sheet to your agency. They will attach the white copy of the time sheet to the appropriate billing form and forward the documents to the billing department for payment.

Immediately report any serious issues or participant needs that you have identified to the nurse monitor and case manager (medical concerns, environmental problems in the home, or possible abuse or neglect).

Immediately report any suspected abuse, neglect or exploitation to Adult Protective Services at 1-800-917-7383.

DHMH 4659 (C – TS) Approved 07/01/06

White Copy – Billing Department Yellow Copy – Nurse Monitor Pink Copy – Participant/Representative Goldenrod – Caregiver