



OFFICE USE ONLY	Program: In-Home Family Support	# Hours:
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CLIENT: Denise Robinson	EMPLOYEE:								
Client/Employee signatures verify that hours worked and services provided are accurately documented here. MONTH: _____ YEAR: _____	DAY	Mon	Tue	Wed	Thur	Fri.	Sat	Sun	TOTAL HOURS
	DATE:								
	Time In								
Time Out									

HOURS WORKED								
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ACTIVITIES COMPLETED WITH CLIENT	Initials	Notes: Please list activities you have done with client that are not bullet listed on this time sheet.
HOUSEKEEPING		
MAKE BED AND ORGANIZE APARTMENT UNIT		
LAUNDRY: CLEAN & FOLD		
EATING AND SET UP		
MEAL PREPARTION		
PERSONAL & CLEANLINESS		
SOCIALIZATION WITH PEERS, FAMILY AND FRIENDS		
HEALTH, SAFETY AND WELLNESS		
RECREATIONAL ACTIVITY		
CUING/STAND BY ASSIST WITH ADLS		

Client Signature: _____ **Date:** _____

Responsible Party/Guardian Signature: _____ **For the Week of:** _____

Employee Signature: _____

TIME SHEETS ARE DUE THE END OF LAST WORK DAY OF THE WEEK: FAX THEM TO 952-953-0187 OR EMAIL THEM TO abdifatah.kofiro@independentlivingpartners.com. THANK YOU.