EMPLOYEE PRINT NAME _____

Circle Title: ICLS ILS Companion Personal Support Respite SLS
Individual Home Supports IHS w/family training IHS w/training IHFS

CONSUMER PRINT NAME _____ MHCP or D.O.B. _____

Cherish LLC

2506 E Beltline - Hibbing, MN 55746

TOTAL TIMESHEET HOURS _____

TIME SHEET **PHONE: (218) 263-9000** **FAX: (218) 263-8336** **SCAN AND EMAIL: becca@cherished1.co**

Week One

	DATE (MM/DD/YY)	TIME IN		TIME OUT		ACTIVITIES	HOURS
Sunday			AM / PM		AM / PM		
Monday			AM / PM		AM / PM		
Tuesday			AM / PM		AM / PM		
Wednesday			AM / PM		AM / PM		
Thursday			AM / PM		AM / PM		
Friday			AM / PM		AM / PM		
Saturday			AM / PM		AM / PM		
*** Document all Activities Performed According to the CSSP Plan						**Weekly Total**	

Staff will report to the responsible party and/or supervisor any changes in health or behavior that they notice while providing services.

Note any hospitalization, incarcerations or care facility dates.

Week Two

	DATE (MM/DD/YY)	TIME IN		TIME OUT		ACTIVITIES	HOURS
Sunday			AM / PM		AM / PM		
Monday			AM / PM		AM / PM		
Tuesday			AM / PM		AM / PM		
Wednesday			AM / PM		AM / PM		
Thursday			AM / PM		AM / PM		
Friday			AM / PM		AM / PM		
Saturday			AM / PM		AM / PM		
*** Document all Activities Performed According to the CSSP Plan						**Weekly Total**	

All timecard documentation will be recorded on the time and date that the service is provided.

Employee Signature	Date
Employee Phone Number:	

Consumer / RP Signature	Date
Consumer / RP Signature Phone Number:	

Signatures verify that the information entered above are accurate and were performed as specified in the consumer service plan and all duties were performed satisfactorily.

It is a Federal Crime to provide false information on billings for Medical Assistance payment. Cherish LLC will investigate and report suspected fraud.