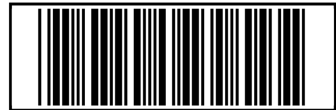
CONSUMER DIRECT CARE NETWORK

Alaska Habilitative Timesheet



For the week of service, timesheets are due the following Monday by midnight if faxed or dropped off, and postmarked by Monday if mailed. Due to the timing of the payroll cycle, late timesheets will result in late pay. Timesheets must be signed AFTER all work is completed. Advance timesheets will not be accepted.

Sunday that started your work week.

__ / __ / __
MM DD YY

Employee Name (Please Print) | **Employee ID** | **Client Name (Please Print)** | **Client ID**

Service Codes: (1) In-Home Supports: T2017U4 (2) Supported Living: T2017 (3) Day Habilitation: T2021

Service Date (MM/DD)	Time In	Time Out	Service 1	2	3	Skills CM	CL	DL	LR	PL	MM	SC	SD	SO
1 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
2 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
3 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
4 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
5 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
6 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
7 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
8 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
9 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
10 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
11 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O
12 __/__	__:__ O AM O PM	__:__ O AM O PM	O	O	O	O	O	O	O	O	O	O	O	O

Skills Key

CM = Communication (using verbal and non-verbal expression, including communication devices)

CL = Community Living (selecting community activities, accessing the community, participating in community activities)

DL = Daily Living (ADLs-hygiene, toileting, bathing, etc. and IADLs-laundry, shopping, meal preparation, etc.)

LR = Learning (acquiring information, problem solving, paying attention)

PL = Personal Living (understanding routines, managing time/money, maintaining a living space)

MM = Mobility/Motor Skills (ambulation, locomotion, fine/gross motor control, physical exercises)

SC = Self-Care (tending to mental, emotional, and spiritual needs, including expressing wishes)

SD = Self-Direction (recognizing boundaries, following rules, processing difficulties)

SO = Socialization (interacting with family, friends, acquaintances, and others)

I certify that the hours and services were provided to the client by the employee as recorded. During these shifts, the employee reminded, observed, supported, and/or trained the client in the skill areas indicated. The client was not in a hospital, nursing home, or institution. False information or misrepresentation constitutes Medicaid fraud and may result in dismissal from the program and/or criminal prosecution.

Employee Signature ____________________ **Date (MM/DD/YY)** __ / __ / __

Client/Representative Signature ____________________ **Date (MM/DD/YY)** __ / __ / __

615 E 82nd Ave, Ste. 101 **Anchorage,** AK99518 Phone: 1-888-966-8777 Fax: (907) 677-8777

126 Pioneer Ave, Ste. 5 **Homer,** AK99603 Phone: (907) 226-1157 Fax: (907) 226-1159

412 Frontage Road, #40 **Kenai,** AK99611 Phone: 1-877-532-8540 Fax: 1-877-532-8541

344 Front St, Ste. A **Ketchikan,** AK99901 Phone: 1-877-270-9581 Fax: 1-800-295-9013

1941B Mill Bay Road **Kodiak,** AK99615 Phone: (907) 481-3070 Fax: (907) 481-3071

131 E. Swanson Ave, Ste. 1 **Wasilla,** AK99654 Phone: 1-888-900-7962 Fax: 1-866-495-7963

17799

HABILITATIVE PROGRESS REPORT

Client Name (print): ________________________________ **Sunday that started your work week:** _____/_____/_____

Service Type	Support Codes		
DH = Day Habilitation **IH** = In-Home Support **SL** = Supported Living	**I** = Independent/no assistance required	**PC** = Physical cues*	**V** = Verbal cues*
	M = Modeling*	**PS** = Protective supervision	**Other:**
	N/A = Not attempted/unable to attempt	**R** = Refused/non-compliant	**Other:**
	P = Physical assistance	**U** = Attempted but unable to complete	* = Requires frequency (for example:V3)

Objective # Reference the objective cue sheet(s).	**Service Type** One service type per objective. DH may only be provided in a community setting.						**Enter the date of service under each day's letter below.**						
							S _______	**M** _______	**T** _______	**W** _______	**T** _______	**F** _______	**S** _______
							For each day of service, enter a support code, as well as the number of times each objective was addressed. Example: V3/4						
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/
		DH		IH		SL	/	/	/	/	/	/	/

Any objective not noted above will be assumed to be marked N/A. Routine failure to address an objective is not acceptable and will be questioned by the agency. Unusual service circumstances leading to an objective not being addressed **MUST** be directly reported to the agency!

Employee Name:	**Signature:**	**Date:**

Employee signature confirms that any day habilitation services were provided in an appropriate community setting, or as otherwise authorized by the State of Alaska and CDCN.

Reports are due by 8 AM each Tuesday.

HABILITATIVE TIMESHEET
DAILY CASE NOTES

Client Name (print)**:** ____ **Sunday that started your work week:** _____/_____/_____

Check all support and teaching strategies used this week:

☐ Administered ☐ Coached ☐ Coordinated ☐ Encouraged ☐ Explored ☐ Followed Up ☐ Instructed ☐ Participated
☐ Practiced ☐ Praised ☐ Pre-Taught ☐ Redirected ☐ Role Played ☐ Used Visual Learning Aids
☐ Used Adaptive Equipment ☐ Other: ________________ ☐ Other:_______________ ☐ Other:_______________

SUNDAY: _____/_____ **If only one type of service was provided, you may use all lines to complete your note.**
IH or SL:

DH:

MONDAY: _____/_____ **If only one type of service was provided, you may use all lines to complete your note.**
IH or SL:

DH:

TUESDAY: _____/_____ **If only one type of service was provided, you may use all lines to complete your note.**
IH or SL:

DH:

WEDNESDAY: _____/_____ **If only one type of service was provided, you may use all lines to complete your note.**
IH or SL:

DH:

THURSDAY: _____/_____ **If only one type of service was provided, you may use all lines to complete your note.**
IH or SL:

DH:

FRIDAY: _____/_____ **If only one type of service was provided, you may use all lines to complete your note.**
IH or SL:

DH:

SATURDAY: _____/_____ **If only one type of service was provided, you may use all lines to complete your note.**
IH or SL:

DH:

Employee Name: **Signature:** **Date:**

Rev 04032018

For the week of service, timesheets are due the following Monday by midnight.