CONSUMER DIRECT CARE NETWORK

Clear Form

Alaska Habilitative Timesheet

18108

Employee Name (Please Print)	Employee ID	Client Name (Please Print)	Client ID	Sunday that started your work week
				MM / DD / YY

Service Codes: In-Home Support (IHS): T2017 U4 Supported Living (SL): T2017 Day Habilitation (DH): T2021

H = Home, C = Community — Location of Service

Service Date Month (MM) Day (DD)	Time In Hour (HH) Min (MM)	Time Out Hour (HH) Min (MM)	IHS	SL	DH	H / C	If community, note location(s) (or, if DH shift, submit DH mileage log):
/	: AM PM	: AM PM				H / C	

Objective Number								Skill Number							
Support Code / Number of Times Addressed	/	/	/	/	/	/	/								

Case Notes: Describe the skill-building activities completed during the shift. You may also mark down additional objectives addressed, or add other comments as outlined in the *Habilitative Service Documentation Guide*.

Service Date Month (MM) Day (DD)	Time In Hour (HH) Min (MM)	Time Out Hour (HH) Min (MM)	IHS	SL	DH	H / C	If community, note location(s) (or, if DH shift, submit DH mileage log):
/	: AM PM	: AM PM				H / C	

Objective Number								Skill Number							
Support Code / Number of Times Addressed	/	/	/	/	/	/	/								

Case Notes: Describe the skill-building activities completed during the shift. You may also mark down additional objectives addressed, or add other comments as outlined in the *Habilitative Service Documentation Guide*.

Mark the support and teaching strategies used during the shifts recorded above:

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

Attestation: I certify that the hours and services recorded on this timesheet were provided to the client by the employee; that the client was not in a hospital, nursing home, or institution when services were provided; and that original entries for each recorded shift, including associated entries on any related service documents, were completed within 14 days of the date on which each shift ended. I understand that submitting false or misleading service documentation is considered Medicaid fraud and may result in dismissal, criminal prosecution, and/or other penalties.

Employee Signature _____ **Date (MM/DD/YY)** / /

Client/Representative Signature _____ **Date (MM/DD/YY)** / /

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