



Maplewood Home Care

seniorhomeinc.com

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Adult Companion Services Time and Activity Documentation

Client Name:	MA #	DOB
Companion Name:	Provider #	

Dates / Times / Location of Recipient's stay in: Hospital, Care Facility, Incarceration

Dates of Service mm/dd/yyyy	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Attend movie to practice coping skills to manage social anxiety							
Going to community event to reduce social isolation							
Playing board games to enhance fine motor skills							
Provide verbal instructions or cues to help complete a task							
Assist or supervise person with task such as laundry							
Assist or supervise person with task such as light housekeeping							
Assist or supervise person with task such as meal preparation							
Assist or supervise person with task such as shopping to practice budgeting skills							

Time in (circle AM/PM)	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
Time out (circle AM/PM)	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM

Daily Total Minutes							
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**Weekly Total Minutes
This Time Sheet**

Acknowledgment and Required Signatures

After the Companion has documented his/her time and activity, the client must draw a line through any dates/times he/she did not receive services from the Companion. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on Adult Companion Services billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the Adult Companion Services Support Plan.

Client Signature	DATE
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I certify and swear under penalty of law that I have accurately reported on this time sheet the hours I actually worked, the services I provided, and the dates and times worked. I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings.

Companion Signature	DATE
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