

PSA Helper Name: \_\_\_\_\_

Recipient (Child's) Name: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Family Address: \_\_\_\_\_

Pay Period: From ( \_\_\_/\_\_\_/\_\_\_ ) To ( \_\_\_/\_\_\_/\_\_\_ )

Medicaid ID #: \_\_\_\_\_

**Technology Assisted Personal Service Attendant (PSA) Time Sheet**

Date Mo/day/year	Weekday (MON, TUE, WED, THUR, FRI, SAT, SUN)	Time In	Time Out	Time In	Time Out	Total Hours
		AM	AM	PM	PM	
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TOTAL HOURS: \_\_\_\_\_

Other comments concerning change in Recipients condition or care: \_\_\_\_\_

By signing this timesheet, we (Helper and Parent/Guardian) certify that the service hours recorded on this form are correct and the service was satisfactorily performed. We also verify that all the required documentation of times worked, tasks performed and frequency of care have been appropriately recorded on the Personal Service Attendant Worksheet and kept. We also attest to the following:

1. The PSA named above worked the above logged dates and times attending to the needs of the Participant. PSA and Parent/Legal Guardian understand that if any of the above logged hours were not worked as documented, even if by agreement between the Parent/Legal Guardian and the PSA, it would be considered fraud and exploitation as defined by the State of Kansas.
2. Time sheets are to be kept at the place of employment and hours are documented as they occur.
3. No other home care agency, hospital, nursing facility, ICF/MR, or IMD was providing care for the Recipient during any of the above logged dates and times.
4. Tasks provided were identified as necessary tasks authorized and delegated on the PSA Skills Checklist
5. The PSA has had no legal arrest or investigations during the term of this time sheet that have not been disclosed to the Parent/Legal Guardian and the Fiscal Management Service (FMS).
6. Any changes in the Recipient's medical status or care has been documented and a new PSA Skills Checklist has been revised as appropriate.
7. Attendant Care Services on the TA waiver may not exceed 12 hours per day.

\_\_\_\_\_/\_\_\_\_\_  
Signature of PSA Helper / Date

\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent or Guardian / Date

**Please fax to 913-221-0379 or e-mail to info@helpersinc.org within 48 hours of the billing cycle.**  
For assistance call 913-322-7212.

This form contains personal identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to:  
Helpers, Inc. | 12980 Metcalf Ave., Ste. 200 | Overland Park, KS 66213

**Participant:**

**PSA:**

**Note:** Dates should correspond with accompanied timesheet. On a daily basis the PSA should "X" the services they provided that day. At the end of each day PSA and Parent/Legal Guardian should initial where indicated. PSA and Parent/Legal guardian should sign the bottom of the document before submitting to the Fiscal Management Service (FMS).

Month: _____ Year: _____		Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day
<b>ADL's...</b>	Lifting/Body Mechanics/Transfer/Positioning																
	Dressing/Bathing/Hair/Oral/Skin/Nail																
	Diet/Nutrition Prep/Clean-up																
	Toileting/Diapering/Personal Adjustment																
	Housekeeping/Laundry																
	Ambulation Technique Assistance																
<b>Health...</b>	Medication Administration																
	Oxygen Administration																
	CPR/First Aid																
	Emergency Procedures																
	Tracheotomy Care																
	Seizure Control																
	Infection Control																
	Suction Machine Use																
	Glucometer Use (blood sugar monitoring)																
	Vital Sign Monitoring (Temp,BP,Pulse,Pulse Ox,Resp)																
	NG/GT/NJ Feeding and Care																
	Catheter Care/Recording Input & Output																
	Enema/Suppository Insertion																
	Range of Motion Exercises																
	Documentation/Record Keeping																
<b>Support...</b>	Recreation/Socialization																
	Transportation																
	Hearing Impaired Assistance																
	Visually Impaired Assistance																
	Communication Technique Assistance																
	Behavior Modification Technique Assistance																
<b>Other</b>																	
	Initials of PSA to verify that the services were provided.....																
	Initials of Parent/Legal Guardian to verify that services were provided..																

**General Notes & Comments (If additional room is required please attach additional notes as needed)**

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PSA Attendant Signature

\_\_\_\_\_  
Date