

Helper Name: _____

Recipient (Child's) Name: _____

Last 4 digits of S.S. #: ____ _

Parent/Guardian Name: _____

Address: _____

Family Address: _____

City, State, Zip: _____

Medicaid ID #: _____

Phone: _____

Pay Period:
From (___/___/___) To (___/___/___)

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
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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 the above logged dates/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 913-322-7250 or e-mail to info@helpersinc.org within 48 hours of the billing cycle.

For assistance call 913-322-7212.

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	Day
ADL's...	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																	
Health...	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																	
Support...	Recreation/Socialization																	
	Transportation																	
	Hearing Impaired Assistance																	
	Visually Impaired Assistance																	
	Communication Technique Assistance																	
	Behavior Modification Technique Assistance																	
Other																		
	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