Client *(Print Name)*

Direct Service Worker *(Print Name)*

Three Rivers Inc.

504 Miller Dr., PO Box 408
Wamego, KS 66547-0408
Phone: (785) 456-8573
Fax: (785) 456-9923

SR CARE ACT
Attendant Care Timesheet

From: /1/ (mm/dd/yy) To: /15/ (mm/dd/yy)

Attendant Care ☐ Homemaker ☐

Date	Duties Provided	Start Time	End Time	Start Time	End Time	Start Time	End Time	Total Hours
1st		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
2nd		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
3rd		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
4th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
5th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
6th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
7th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
8th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
9th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
10th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
11th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
12th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
13th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
14th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
15th		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	

The above hours must be received before noon on the 17th

Pay Period Total

Sign after work is completed for the pay period.

DSW Initials	Client Initials

Client Signature **Date**

My signature verifies that this information is correct. Submission of claims for time beyond what is allowed on my Plan of Care may be considered Fraud.

DSW Signature **Date**

My signature verifies that this information is correct. I understand that I am only authorized to work hours allowed by the approved Plan of Care. Submission of claims for time beyond what is allowed may be considered Fraud.

Duties Legend	
A	Bathing/Grooming
B	Dressing/Undressing
C	Toileting
D	Transfer
E	Walking/Mobility
F	Eating
G	Meal Preparation
H	Shopping
I	Money Management
J	Transportation (accompanying)
K	Laundry/Housekeeping
L	Management of Meds

Office Use Only

Payroll Date _____

Entered Date _____

OPOC _____

PS _____

MO/Trans

R 7/2013