**Consumer** *(Print Name)*

**Transitional Living Skills Worker or Job Coach** ***Print Name***

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

**TLS or Job Coach Timesheet**

| **Pay Period** | |
|---|---|
| From: | |
| To: | |

**mm/dd/yy to mm/dd/yy**

| Date | Duties Provided | Start Time | End Time | Start Time | End Time | Start Time | End Time | Total Hours |
|---|---|---|---|---|---|---|---|---|
| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
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| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
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| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
| | | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | |
| | | | | | | **Pay Period Total** | | |

**Sign after work is completed for the pay period.**

**Consumer Signature** **Date**

*My signature verifies that this information is correct.*

**Employee 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.*