



**State of Connecticut-Department of Social Services
Timesheet/Activity Check List**

FAX to: 860-627-5986
MAIL to: P.O. Box 479
East Windsor, CT 06088-0479
EMAIL to: acr@alliedgroup.org

W-993 (Rev.04-18)

Pay Period Ending Date

□□ / □□ / □□□□

Check this box if you are revising a timesheet previously submitted

Select One: ABI CHCPE MFP CHCPE MFP CFC
 ABI II CHCPD MFP PCA MFP ABI
 AUT CFC MFP ABI II PCA

Part I: Employee Information

Employee First Name:

□□□□□□□□□□□□□□□□□□

Employee Last Name:

□□□□□□□□□□□□□□□□□□

Last Four Digits of SSN

□□□□

Part II: Participant/Employer Information

Print First Name of Participant - Employer:

□□□□□□□□□□□□□□□□□□

Last Name of Participant - Employer:

□□□□□□□□□□□□□□□□□□

Telephone Number

(□□□□) □□□□ - □□□□□□

Part III: Timesheet

Day	Date Mo/Day	Service	Time In	Time Out	Time In	Time Out	Total Hours for Day
Sun	□□ / □□	□□□□	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ . □□
Mon	□□ / □□	□□□□	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ . □□
Tues	□□ / □□	□□□□	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ . □□
Wed	□□ / □□	□□□□	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ . □□
Thur	□□ / □□	□□□□	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ . □□
Fri	□□ / □□	□□□□	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ . □□
Sat	□□ / □□	□□□□	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ : □□ <input type="radio"/> AM <input type="radio"/> PM	□□ . □□

Service Key: Companion-COM Personal Care Asst.-PCA Respite-RES Homemaker-HM Overnights-ON Per Diem-PD Independent Living Skills Trainer-ILS Life Skills Coach-LIF Community Mentor-CM Job Coach-JOB Homemaker-HM

Total Weekly Hours: □□ . □□

Part IV: Employee Daily Activity Check List

	SU	M	T	W	TH	F	S		SU	M	T	W	TH	F	S
Bathing	<input type="radio"/>	Mobility assistance inside & outside	<input type="radio"/>												
Dressing/Undressing	<input type="radio"/>	Laundry	<input type="radio"/>												
Light Housework	<input type="radio"/>	Errands (shopping, banking, etc.)	<input type="radio"/>												
Eating	<input type="radio"/>	Meal Preparation	<input type="radio"/>												
Toileting and/or Bladder & Bowel Routine	<input type="radio"/>	Taking Medicine	<input type="radio"/>												
								Accompany Medical Transport	<input type="radio"/>						
Grooming/Hygiene	<input type="radio"/>	Exercise Regimen	<input type="radio"/>												
Transfers (not included in any other activity)	<input type="radio"/>	Personal Business (bill paying, written & phone communications, etc.)	<input type="radio"/>												

Notes:

I Certify that the information supplied above regarding hours worked and activities performed is accurate. I also certify that my employer was not an inpatient in a hospital, nursing facility, or other medical or non-medical institutional setting during this time period.

Employee Signature □□ / □□ / □□
Date

I Certify that this time sheet/activity check list was completed in full BEFORE I signed it and that the above information regarding hours worked and activities performed is accurate. I also certify that I was not an inpatient in a hospital, nursing facility, or other medical or non-medical institutional setting during this time period.

Employer Signature □□ / □□ / □□