

PERSONAL SUPPORT/RESPIRE – AHS

Client Name _____ Employee Name _____ File # _____

For the week of: **Sunday** _____ thru **Saturday** _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date:	Date:	Date:	Date:	Date:	Date:	Date:
Time In:	Time In:	Time In:	Time In:	Time In:	Time In:	Time In:
Time Out:	Time Out:	Time Out:	Time Out:	Time Out:	Time Out:	Time Out:
<p><i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i></p> <p>_____ Personal Support</p> <p>_____ Respite Hourly</p> <p>_____ Respite Out-of-Home Hourly</p> <p>_____ Chore</p> <p>_____ Other</p>						
<p><i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i></p> <p>_____ Personal Support</p> <p>_____ Respite Hourly</p> <p>_____ Respite Out-of-Home Hourly</p> <p>_____ Chore</p> <p>_____ Other</p>						
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<p><i>Please indicate the program in which you worked for this day and specify the number of hours for all that apply:</i></p> <p>_____ Personal Support</p> <p>_____ Respite Hourly</p> <p>_____ Respite Out-of-Home Hourly</p> <p>_____ Chore</p> <p>_____ Other</p>						
Total Hours:	Total Hours:	Total Hours:	Total Hours:	Total Hours:	Total Hours:	Total Hours:
<p>Client/Responsible Party and Staff MUST review the complete time sheet for accuracy before signing. Your signature verifies the time and services entered above are accurate and that the client was not admitted to another facility during the times provided (i.e. hospital, ICF-MR or Respite facility).</p>						Total Hours for Week:
EMPLOYEE SIGNATURE:					DATE SIGNED:	
CLIENT/RESPONSIBLE PARTY SIGNATURE (Please authorize all hours before signing here):					DATE SIGNED:	

NOTE: ALL TIMESHEETS MUST BE RECEIVED EVERY MONDAY BY 10:00 AM FOLLOWING THE WEEK WORKED. PLEASE CALL AFTER YOU SEND YOUR TIMESHEETS TO MAKE SURE THEY WERE RECEIVED. BLANK TIMESHEETS CAN BE FOUND AT OUR WEBSITE WWW.ALLIANCEHEALTHCARE.COM