METROPOLITAN COMMUNITY SERVICES
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CFSS TIME & ACTIVITY DOCUMENTATION

☐ Regular ☐ Extended

Participant Name:_____

Dates of Service (mm/dd/yy)	WEEK 1							WEEK 2						
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Activities	Check for each covered activity under the date indicated.							Check for each covered activity under the date indicated.						
Dressing														
Grooming														
Bathing														
Eating														
Transfers														
Mobility														
Positioning														
Toileting														
Health Related														
Behavior														
IADLs														

Dates/Location of Recipient stay in Hospital/Care Facility/Incarceration (no hours can be claimed):	Admit (Date/Time)	Discharged (Date/Time)	Location

VISIT INFORMATION

	Day	Date	VISIT 1 Time In	VISIT 1 Time Out	VISIT 2 Time In	VISIT 2 Time Out	Daily Total
WEEK 1	MON		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	TUE		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	WED		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	THU		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	FRI		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SAT		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SUN		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
						Week 1 Total	

	Day	Date	VISIT 1 Time In	VISIT 1 Time Out	VISIT 2 Time In	VISIT 2 Time Out	Daily Total
WEEK 2	MON		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	TUE		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	WED		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	THU		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	FRI		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SAT		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SUN		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
						Week 2 Total	

Participant's Signature

Review for accuracy before signing. It is a crime to provide false information on billings for Medical Assistance payments. By signing you swear and verify the time/services entered are accurate and that services were performed by the worker listed below as specified in the person's plan.

NAME (FIRST NAME & LAST NAME)	DOB	PARTICIPANT/REPRESENTATIVE'S SIGNATURE	DATE

CFSS worker's signature

I declare under penalty of perjury that all hours worked and descriptions of work performed contained in the submitted shifts are true and correct with full knowledge that all of this information may be subject to investigation and that any false or dishonest information contained on these shifts may be grounds for denial of payment and/or reporting of findings to the investigation unit of the Department of Human Services.

CFSS WORKER (FIRST NAME & LAST NAME)	UMPI #	SIGNATURE	DATE

Instructions for CFSS Time and Activity Documentation

- This form documents time and activity between one DSW and one participant. Document up to two visits per day on this form. Use additional forms if you do more than two visits per day.
- Use Black Pen Only.
- Week 1 is the 1st week of the Pay Period; Week 2 is the 2nd week of Pay Period (See Payroll Schedule).

DATES OF SERVICE

Dates of service must be in consecutive order. Enter the date in mm/dd/yy format for each date you provide service. The participant must draw a line through any dates and times CFSS services were not provided.

PARTICIPANT STAYS

Enter dates and location of recipient stays in a hospital, care facility or incarceration.

ADLs (ACTIVITIES OF DAILY LIVING)

For each date you provided care, write your initials next to all the activities you provided. Your initials indicate you provided the service as described in the Service Delivery Plan. If you provide a service more than once a day, initial only once. The following are general descriptions of activities of daily living and instrumental activities of daily living.

- **Dressing**

Choosing appropriate clothing for the day includes laying out of clothing, actual applying and changing clothing, special appliances or wraps, transfers, mobility and positioning to complete this task.

- **Grooming**

Personal hygiene includes basic hair care, oral care, nail care (except recipients who are diabetic or have poor circulation), shaving hair, applying cosmetics and deodorant, care of eyeglasses, contact lenses, hearing aids.

- **Bathing**

Starting and finishing a bath or shower, transfers, mobility, positioning, using soap, rinsing, drying, inspecting skin and applying lotion.

- **Eating**

Getting food into the body, transfers, mobility, positioning, hand washing, applying of orthotics needed for eating, feeding, preparing meals and grocery shopping

- **Transfers**

Moving from one seating/reclining area or position to another.

- **Mobility**

Moving includes assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient.

- **Positioning**

Including assistance with positioning or turning a recipient for necessary care and comfort.

- **Toileting**

Bowel/bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area and inspecting skin and adjusting clothing.

HEALTH-RELATED PROCEDURES AND TASKS

Health related procedures and tasks according to PCA policy. Examples include range of motion and passive exercise, assistance with self-administered medication including bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, interventions, monitoring and observations for seizure disorders, and other activities listed on the care plan and considered within the scope of the PCA service meeting the definition of health-related procedures and tasks.

BEHAVIOR

Redirecting, intervening, observing, monitoring and documenting behavior.

IADLs (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)

Covered service for recipients over age 18 years only, such as: meal planning and preparation, basic assistance with paying the bills, shopping for food, clothing, and other essential items, performing household tasks integral to the personal care assistance services; assisting with recipient's communication by telephone, and other media, and accompanying the recipient with traveling to medical appointments and participation in the community.

DATE

Enter the date in mm/dd/yy format for each date you provide service.

VISIT 1

Documentation of the first visit of the day.

Time In: Enter exact time in hours and minutes that you started providing care and check AM or PM.

Time Out: Enter the exact time in hours and minutes that you stopped providing care and check AM or PM.

If your shift is 8 hours or more, you must document a minimum of 30 minutes for lunch break.

VISIT 2

Same as Visit 1.

DAILY TOTAL

Add the total time in hours and minutes that you spent with this client for the care documented in each row.

WEEKLY TOTAL

Add the time in hours and minutes for all visits on this entire timesheet and enter the total in the appropriate box.

ACKNOWLEDGEMENT AND REQUIRED SIGNATURES

Participant/responsible party prints the participant's first name and last name, and MA Member Number (PMI #) or birth date. Participant/ responsible party signs and dates form. DSW prints his/ her first and last name, individual PCA Unique Minnesota Provider Identifier (UMPI). DSW signs and dates form.