EMPLOYEE PRINT NAME _____ ICLS Staff

CONSUMER PRINT NAME _____ **MHCP OR D.O.B.** _____

Cherish LLC - ICLS Timesheet

2900 E Beltline Suite 8 - Hibbing, MN 55746

TOTAL TIMESHEET HOURS _____

TIME SHEET

PHONE: (218) 263-9000 FAX: (218) 263-8336 EMAIL: bari@cherished1.co

YEAR _____	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	TOTAL HOURS
MONTH / DAY															
START TIME															
END TIME															
TOTAL HOURS															
Services Provided	**USE AM OR PM** - - - - MARK WHICH ACTIVITIES YOU PERFORMED THAT VISIT **ACCORDING TO THE SERVICE PLAN**														
Adaptive Support Service															
Activities of Daily Living															
Active Cognitive Support															
Household Management															
Health Safety & Wellness															
Community Engagement															

Note all hospitalizations, incarcerations or care facility dates:

Staff will report to the responsible party and/or supervisor any changes in health or behavior that they notice while providing services.

_____ _____ _____ _____

Employee Signature **Date** **Consumer/Responsible Party Signature** **Date**

Employee Phone _____ Consumer Phone _____

Signatures verify that the information entered above are accurate and were performed as specified in the consumer service plan and all duties were performed satisfactorily and that this completed form may be sent to Cherish LLC by electronic communications including email.

It is a Federal Crime to provide false information on billings for Medical Assistance payment. Cherished Home Management will investigate and report suspected fraud.