



HOME AND COMMUNITY SERVICES (HCS)
 DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
Individual Provider Time Sheet

CLIENT/EMPLOYER NAME				INDIVIDUAL PROVIDER'S NAME				CM NAME				MONTH/YEAR					
Day of Month		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A	Time Service Began																
B	Time Service Ended																
C	Total Hours Each Day																
D	Mileage																
Day of Month		17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTALS
A	Time Service Began																
B	Time Service Ended																
C	Total Hours Each Day																
D	Mileage																
CHECK TASKS PERFORMED DURING MONTH AS ASSIGNED IN CLIENT'S SERVICE PLAN (PERSONAL CARE PROVIDERS ONLY)																	
<input type="checkbox"/> Meal Preparation <input type="checkbox"/> Dressing <input type="checkbox"/> Walking / Locomotion <input type="checkbox"/> Bathing <input type="checkbox"/> Essential Shopping															<input type="checkbox"/> DDD Respite		
<input type="checkbox"/> Eating <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Application of Lotion / Ointment <input type="checkbox"/> Toileting <input type="checkbox"/> Wood Supply															<input type="checkbox"/> Dry Bandage Change		
<input type="checkbox"/> Escort / Transport to Medical <input type="checkbox"/> Bed Mobility / Positioning <input type="checkbox"/> Toenails Trimmed* <input type="checkbox"/> Housework <input type="checkbox"/> Passive Range of Motion Treatment															<input type="checkbox"/> Medication Management		
* Tasks for adult clients only.																	
INSTRUCTIONS FOR DOCUMENTING YOUR DSHS AUTHORIZED HOURS																	
A. Enter time service began – indicate AM or PM as appropriate. C. Enter total hours worked each day. B. Enter time service ended – indicate AM or PM as appropriate. D. Mileage: All miles traveled transporting or shopping for a client when authorized per SSPS.																	
DO NOT send these time sheets to Case Managers unless requested. Keep completed time sheets in your records for six (6) years. Copies will be requested by Case Managers at the time of reassessment. DSHS may request copies at any time.																	
CLIENT'S SIGNATURE									INDIVIDUAL PROVIDER'S SIGNATURE								

This form is available at <https://www.dshs.wa.gov/fsa/forms>