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

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W-993 (Rev.04-18)

Pay Period Ending Date

☐☐ / ☐☐ / ☐☐☐☐

☐ Check this box if you are revising a timesheet previosuly submitted

Select One: ○ **ABI** ○ **ABI II** ○ **AUT** ○ **CHCPE** ○ **CHCPD** ○ **CFC** ○ **MFP CHCPE** ○ **MFP PCA** ○ **MFP ABI II** ○ **MFP CFC** ○ **MFP ABI** ○ **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	☐☐/☐☐	☐☐☐	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐.☐☐
Mon	☐☐/☐☐	☐☐☐	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐.☐☐
Tues	☐☐/☐☐	☐☐☐	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐.☐☐
Wed	☐☐/☐☐	☐☐☐	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐:☐☐ ○AM ○PM	☐☐.☐☐
Thur	☐☐/☐☐	☐☐☐	☐☐:☐☐ ○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	☐☐.☐☐

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	○	○	○	○	○	○	○	Mobility assistance inside & outside	○	○	○	○	○	○	○
Dressing/Undressing	○	○	○	○	○	○	○	Laundry	○	○	○	○	○	○	○
Light Housework	○	○	○	○	○	○	○	Errands (shopping, banking, etc.)	○	○	○	○	○	○	○
Eating	○	○	○	○	○	○	○	Meal Preparation	○	○	○	○	○	○	○
Toileting and/or Bladder & Bowel Routine	○	○	○	○	○	○	○	Taking Medicine	○	○	○	○	○	○	○
								Accompany Medical Transport	○	○	○	○	○	○	○
Grooming/Hygiene	○	○	○	○	○	○	○	Exercise Regimen	○	○	○	○	○	○	○
Transfers (not included in any other activity)	○	○	○	○	○	○	○	Personal Business (bill paying, written & phone communications, etc.)	○	○	○	○	○	○	○

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 ☐☐/☐☐/☐☐