FAMILIES FIRST

TIME SHEET

EMPLOYEE: _____ PAY PERIOD: _____ - _____

WEEK ONE:

DATE	START TIME	STOP TIME	TOTAL TIME	CONSUMER (First Initial, Last Name)	Comm Support B01	Work C04	Serv Coord A01	Clinical E01	Home Support H01	Asst Living H02	Respite (Hourly) D01	Respite (Days) D02	Personal Care X01	Bridge Case Mgmt X01	CFC Z02	DAIL Z03	TBI Z01	V	S	H

WEEK TWO:

DATE	START TIME	STOP TIME	TOTAL TIME	CONSUMER (First Initial, Last Name)	Comm Support B01	Work C04	Serv Coord A01	Clinical E01	Home Support H01	Asst Living H02	Respite (Hourly) D01	Respite (Days) D02	Personal Care X01	Bridge Case Mgmt X01	CFC Z02	DAIL Z03	TBI Z01	V	S	H

EMPLOYEE SIGNATURE & DATE

PARENT/GUARDIAN SIGNATURE & DATE

SUPERVISOR SIGNATURE & DATE