Fax: 763-208-6089
Email to: hr@sincerehomecaremn.com

SINCERE HOME CARE
REAL PEOPLE. SUPREME SUPPORT.

Independent Living Skills (ILS) Time Report

Employee's Name: _____ 2 – Week Pay Period: Mon: _____ (mm/dd/yy) Sun: _____ (mm/dd/yy)

Client's Name: _____ Client's Representative: _____

Dates of Service Week One	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time In	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM
Time Out	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM
Total hours per day							
					Total for the week one		

Dates of Service Week Two	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time In	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM
Time Out	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM
Total hours per day							
					Total for the week two		

Wage/hour	$	Total hours for the two weeks	

Has the Client been in the Hospital, a Care Facility or Incarcerated during these two weeks? Yes ☐ No ☐
If so, please complete the following: Admit Date: _____ Discharge Date: _____
No hours can be claimed if Client is in the hospital, nursing home or out of home placement.

NOTICE: Your signature verifies the times entered above are accurate and that the services were performed as specified in the Personal Care Plan. This time report is not valid unless signed by both parties. It is a Federal Crime to provide false information on this time report.

_____ _____ _____ _____
Employee's Signature Date Client/Client Representative's Signature Date

For Office Use Only:
Billed: _____
Total Wages: _____
Entered on S.S: _____