



NYS OPWDD Consolidated Supports and Services (CSS) Employee Time Sheet/Daily Service Record

Financial Management Services (FMS) Agency: _____

Participant's Name: _____ Participant's Medicaid CIN: _____

Employee's Name: _____ Employee's Title: _____

Time Sheet for Period Ending: _____ Primary Service Locations: _____

Valued Outcomes: (Enter the participant's valued outcomes and the supports and services associated with each outcome.)

- | | |
|-----------|-----------|
| A) | B) |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| C) | D) |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

Put your initials in the "Initials" box below for each date a service was provided. This is your attestation that the service was provided on that day.

Day	Date: Mo/Day	Hrs Worked From/To	Tot Hrs Charged	Face-to-Face (y/n)	Specify the <u>Staff Action</u> Provided in Support of a Valued Outcome (service locations may be noted)	Initials
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Sun						
Total hours worked this week						

Additional Comments: _____

Day	Date: Mo/Day	Hrs Worked From/To	Tot Hrs Charged	Face-to-Face (y/n)	Specify the <u>Staff Action</u> Provided in Support of a Valued Outcome (service locations may be noted)	Initials
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Sun						
Total hours worked this week						

Additional Comments: _____

Check here if there is a shared staff arrangement (more than 1 person served at same time) Identify other persons served _____

Signing and submitting false information may lead to a charge of Medicaid fraud.

Signature of Employee: _____ Initials: _____ Date: _____

Signature of Participant/Designee: _____ Date: _____

Participant: Original to FMS

For FMS Use Only – Payroll Authorization _____ (FMS Initials)