

Self-Hired Employee Time Sheet (Biweekly) and Service Documentation

Individual's Name: _____ Individual's Medicaid CIN: _____

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

Fiscal Intermediary (FI) Agency: _____

- Service Type: Community Habilitation
 Intensive SEMP
 Extended SEMP
 Respite

Primary Service Location(s): _____

Time Sheet for Period Ending (mo/day/year): _____

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

Day	Date: Mo/Day	Hrs Worked: From/To	Total Hrs Worked	Face-to-Face Time	Non-billable Time	Service Description (Specify the <u>type of support</u> provided by staff)	Initials
Mon		/					
Tue		/					
Wed		/					
Thu		/					
Fri		/					
Sat		/					
Sun		/					
Total hours worked							

Comments: _____

Day	Date: Mo/Day	Hrs Worked: From/To	Total Hrs Worked	Face-to-Face Time	Non-billable Time	Service Description (Specify the <u>type of support</u> provided by staff)	Initials
Mon		/					
Tue		/					
Wed		/					
Thu		/					
Fri		/					
Sat		/					
Sun		/					
Total hours worked							

Comments: _____

Staff-to-individual ratio: 1:1 1:Group

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

Signature of Employee: _____ Initials: _____ Date: _____

Signature of Individual/Designee: _____ Date: _____

Original to Fiscal Intermediary (FI)
FOR FI USE ONLY – Payroll Authorization _____ (FI Initials)

Revised 8/26/15
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