Self-Hired Employee Time Sheet (Weekly) 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 type of support 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 Participant/Designee: _____ Date: _____