

Sylvia's Caring Companions Health Care Services Time Sheet
 PAYROLL AND MEDICARE/MEDICAID SERVICE BILLING DOCUMENTATION

**ORIGINAL PAPERWORK IS DUE
 EVERY OTHER MONDAY
 BEFORE 2:00pm!!!
 NO EXCEPTIONS!!!!!!!!!!!!!!!**

NOW/CCW/LTPCS/SIL/CCS/EPSDT/RESPITE

RECIPIENT SERVED: _____

DAY	DATE Please put complete date 00/00/00	START TIME IN AM/PM	TIME OUT AM/PM	TIME IN AM/PM	TIME OUT AM/PM	TIME IN AM/PM	TIME OUT AM/PM	TIME IN AM/PM	TIME OUT AM/PM	TIME IN AM/PM	FINISH TIME OUT AM/PM	TOTAL HRS	TOTAL UNITS	NOTES SHOULD INCLUDE ANY DEVIATIONS FROM THE CPOC, HOSPITAL VISITS OR ADMITS, DISCHARGES & ALL REASONS SERVICES WAS NOT PROVIDED.
SUN.														
MON.														
TUES.														
WED.														
THURS.														
FRI.														
SAT.														
SUN.														
MON.														
TUES.														
WED.														
THURS.														
FRI.														
SAT.														

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT:

DSW SIGNATURE _____ TOTAL SERVICE HOURS _____ TOTAL SERVICE UNITS _____

RECIPIENT SIGNATURE _____ CHECKED BY: _____

If recipient is unable to sign another person 18 yrs. or older must sign to verify that services were provided to the recipient. This person must sign their own name & list relationship to recipient.

SIGNATURE & RELATIONSHIP _____