exas Department of Aging
ınd Disability Services

Consumer Directed Services

Service Delivery Log with Written Narrative/Written Summary

ʼrogram

Participant Name

ʼay Period

Employer Name

ervice Provider Name

Service Type

☐ PAS ☐ SHL ☐ Respite ☐ Community Support ☐ Residential Habilitation ☐ Other ______

Service Date	Time In (AM or PM)	Time Out (AM or PM)	Time In (AM or PM)	Time Out (AM or PM)	Total Hours	Place of Service	Written Narrative Continue narrative on next page, if needed.
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
				Total Hours			

ıe employee and employer certify that the information provided above is complete and accurate and understand that submitting a false or fraudulent time sheet could result in a Medicaid fraud referral.

Signature - Service Provider ______ Date ______

Signature - Employer or DR ______ Date ______

ervice Type:

______ Hours Reg at $______ per hour ______ Hours Sick

______ Hours OT at $______ per hour ______ Hours Holiday

______ Hours Vacation ______ Bonus

☐ Other

CDSA Use Only

imesheet: ☐ Acceptable ☐ Unacceptable ☐ Return to employer

Votes: