Employee Time Sheet / Service Delivery Record

EAK Good Neighbor **Email: timesheets@eakcds.com/Fax: 855-652-0918**

CLIENT NAME	
EMPLOYER/DR NAME	
EMPLOYEE NAME	

Pay Period:

Begin _____ End _____

Tasks were performed according to the authorization for services. (If tasks are authorized, Employer/DR must check box below in order to process timesheet) ☐

Program (please circle) STAR Kids (PCS) STAR Plus PHC Waiver

Type of Service (please circle) HAB PAS PAS/HAB Respite Protective Supervision

DATE	Day	Time In	Time Out	Time In	Time Out	TOTAL TIME WORKED
	Sunday					
	Monday					
	Tuesday					
	Wednesday					
	Thursday					
	Friday					
	Saturday					
	Sunday					
	Monday					
	Tuesday					
	Wednesday					
	Thursday					
	Friday					
	Saturday					

TOTAL:

Employee Signature _____ Date: _____

Employer/DR Signature _____ Date: _____

The Employer/DR and Employee certify that these are the true and correct hours worked, all services provided were according to the current tasks authorized and all services were NOT provided while the client was in the hospital , nursing home or other healthcare facility. Also, by signing the time sheet, Employer/DR and Employee understand that falsification of this time sheet is considered Medicaid fraud and could result in dismissal from the program/services and criminal prosecution.

FMSA USE ONLY: Total per month: _____ Total per month _____ TOTAL HOURS: _____

Revised 06/21/18