Employer/Medicaid number: _____ *All fields must be filled out completely or time sheet will be returned.

# Consumer Choices Option
# Semi-Monthly Time Sheet

Employee*: _____ Social Security number*: _____

Position*: _____ Hourly wage*: _____

**Employer's first and last name*:** _____

Pay period from: _____

| Date* | Start Time* | End Time* | Start Time* | End Time* | Total Hours Worked* | Rate of Pay* | **SERVICE PROVIDED AND NARRATIVE*** Services provided must match service on the individual budget. Please identify in the narrative if hours worked are from the emergency back up plan or from savings. (Use more than one line if needed.) | Note any progress/changes for consumer. |
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Employer/Medicaid number: _____

*All fields must be filled out completely or time sheet will be returned.

| Date* | Start Time* | End Time* | Start Time* | End Time* | Total Hours Worked* | Rate of Pay* | **SERVICE PROVIDED AND NARRATIVE*** Services provided must match service on the individual budget. Please identify in the narrative if hours worked are from the emergency back up plan or from savings. (Use more than one line if needed.) | Note any progress/changes for consumer. |
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Employer/Medicaid number: _____

*All fields must be filled out completely or time sheet will be returned.

All time recorded on the time sheets needs to be documented to the nearest quarter hour. Time sheets must be received by the Financial Management Service within 30 days of the last day of service provided. Time sheets must be submitted by the 7th/22nd days of the month to be paid by the 15th/last day of the month.

**I certify that the person whose name appears on this time sheet has worked the time indicated. I understand that by signing an employee time card which contains false information about hours worked, may make me a party to Medicaid fraud and legal action could occur.**

Did the employee perform the job in a respectful and courteous manner?

☐ Never ☐ Seldom ☐ Sometimes ☐ Usually ☐ Always

Comments:

In the event that my total expenses for this bi-monthly period exceeds my approved allocation, I authorize Veridian Credit Union to use any available funds from my savings in order to assure payment of this time sheet. The employer agrees that the employer is responsible for any employee wages or supports that exceed the individual budget and savings or that are not identified on the individual budget and savings.

_____ _____

Employee's Signature Employer's Signature

_____ _____

Date Date