



Work weeks are Sundays through Saturdays. Time must be submitted by Monday at noon. Time sheets are due every week. Late time or mistakes may result in late pay. Sign the time sheet AFTER all work is complete. Advance time sheets will not be accepted.

Want to avoid the hassle of paper time sheets? Enter your time the quick, easy, and secure way at <https://directmycare.com> today!

Sunday that started your work week

	/		/	
MM		DD		YY

Regular Time Service Code: ATT

Employee Name (Please Print)	Employee ID	Participant Name (Please Print)	Participant ID

Service Type	Service Date		Time In			Time Out		
	Month (MM)	Day (DD)	Hour (HH)	Min - Round to nearest 15 min*		Hour (HH)	Min - Round to nearest 15 min*	
1 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
2 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
3 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
4 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
5 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
6 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
7 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
8 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
9 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
10 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
11 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								
12 <input type="radio"/> Paid Leave <input type="radio"/> Regular Time								

* Rounding to the nearest 15 minutes is allowed by the Department of Labor.

Was the Participant in a hospital, emergency room, urgent care, nursing home, or any other institution or facility at **any time** during this week?

No **Yes** If Yes, please list dates and call office for further instructions.

The hours and services indicated above were provided to the Participant by the Employee as recorded, in accordance with the Care Plan. The Participant was not in a hospital, facility, or incarcerated during this shift. I understand that falsifying this information is Fraud and can result in program removal and/or criminal prosecution.

Employee Signature

Participant/Representative Signature

Date (MM/DD/YY)

Date (MM/DD/YY)

