Self-Hired Employee Time Sheet (Biweekly)
and Service Documentation

Individual's Name: _____ Individual's Medicaid CIN: _____

Employee's Name: _____ Employee's Title: _____

Fiscal Intermediary (FI) Agency: _____

Community Habilitation Prompt Levels/Skill Measurement:	
I = Independent after given initial statement of expectation	**G=**gesture with staff reminder i.e. pointing or touch
V= verbal with one or more instruction	**M=** model with staff demonstration
P= least amount of physical assistance to complete the skill	**R=** refused

Service Type:	☐ Community Habilitation ☐ Intensive SEMP ☐ Extended SEMP ☐ Respite

Primary Service Location(s): _____

Time Sheet for Period Ending (mo/day/year): _____

Put your initials in the "Initials" box for each date a service was provided. This is your attestation that service was provided on that day.

Day	Date: Mo/Day	Service Type	Hrs Worked: From/To	Total Hrs Worked	Face-to-Face Time	Non-billable Time	Service Description (Specify the type of support provided by staff)	Initials
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
Sun								
	Total hours worked							

Day	Date: Mo/Day	Service Type	Hrs Worked: From/To	Total Hrs Worked	Face-to-Face Time	Non-billable Time	Service Description (Specify the type of support provided by staff)	Initials
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
Sun								
	Total hours worked							

Staff-to-individual ratio: ☐ 1:1 ☐ 1: Group

Signing and submitting false information may lead to a charge of Medicaid fraud!

_____ **Initials:** _____ **Date:** _____

Signature of Self-Determination Assistant **Printed Name/Title (Self-Determination Assistant/SDA)**

Signature of Individual/Designee: _____ **Date:** _____

For FI Use only – Payroll Authorization_____ **(FI Initials)**

Updated: 1/12/17

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For each date of service, please include PROGRAM NAME (related to the valued outcome), your STAFF ACTION(S), INDIVIDUAL'S RESPONSE & SATISFACTION to the service provided, LOCATION OF SERVICES. Please SIGN, DATE and include your TITLE (Self-Determination Assistant/SDA) when completing each narrative entry.

Send To: Judy Peck (judy.peck@alleganyarc.org) or Angie Dieter (angie.dieter@alleganyarc.org)
Fax #: 585-593-4529
Address: 50 Farnum Street Wellsville, NY 14895

Signing and submitting false information may lead to a charge of Medicaid fraud!

_____ **Initials:** _____ **Date:** _____
Signature of Self-Determination Assistant **Printed Name/Title (Self-Determination Assistant/SDA)**

Signature of Individual/Designee: _____ **Date:** _____

For FI Use only – Payroll Authorization_____ **(FI Initials)**