

**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:	<input type="checkbox"/> Community Habilitation
	<input type="checkbox"/> Intensive SEMP
	<input type="checkbox"/> Extended SEMP
	<input type="checkbox"/> 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 <u>type</u> 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 <u>type</u> 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!

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

Signature of Individual/Designee: _____ Date: _____

For FI Use only – Payroll Authorization _____ (FI Initials)

