DOCUMENTATION OF SERVICES DELIVERED - CDS

Bi-Weekly

*You may email timesheets to cds@cdsintexas.com or reference the pay schedule for the appropriate fax number to send in your timesheet

Consumer Name:	
Employer Name:	
Service Provider Name:	

Program Selection (Please Circle)

TxHml CLASS PHC DBMD STAR Plus HCS STAR Kids(MDCP) STAR Kids(PCS)

Type of Service (Please Circle)

LVN/RN Transportation Intervener Value Add Respite Other_____

Non EVV Services - Timesheet

Pay Period Number:

**USE 24 HOUR TIME: 8:00 A.M OR 20:00 FOR 8:00 P.M. Enter 12:00 AM as 00:00

DATE	DAY	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL TIME	COMMENTS / NARRATIVE
	Sunday								
	Monday								
	Tuesday								
	Wednesday								
	Thursday								
	Friday								
	Saturday								
	Sunday								
	Monday								
	Tuesday								
	Wednesday								
	Thursday								
	Friday								
	Saturday								

Total Payroll / Pay Period Hours Delivered:

Service:_____

_____ Hours Vacation

_____ Hours Sick

_____ Hours Holiday

_____ Bonus

_____ Other _____

FMSA Agency Only

Date Processed:

By Whom:

FMSA Comments

Was the consumer hospitalized or in an medical care facility during this pay period? Please list dates:_____

Employer and Employee here by certify that the work hours listed above are accurate, that the services provided are in accordance with the current tasks authorized and the services were NOT provided while the consumer was in the hospital, nursing home, or the Medicaid-reimbursed healthcare facility. I understand that falsification of this time sheet is considered Medicaid Fraud, and may result in dismissal from the program and criminal prosecution.

Service Provider Signature **Date**

Employer or DR Signature **Date**