PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 07/09/17 to 07/22/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
07/09/17												
07/10/17												
07/11/17												
07/12/17												
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SubTotals Wk 1												
07/16/17												
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07/18/17												
07/19/17												
07/20/17												
07/21/17												
07/22/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

This is the approved timesheet for PDS. One timesheet shall be used for each employee. The participant/representative/employer is responsible for accurate accounting and reporting of time. The amount referenced does not represent amount paid after taxes withheld. By signing, the participant/ representative/ employer and employee certify that all information is true and correct.

Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 07/23/17 to 08/05/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
07/23/17												
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SubTotals Wk 1												
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07/31/17												
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08/02/17												
08/03/17												
08/04/17												
08/05/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 08/06/17 to 08/19/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
08/06/17												
08/07/17												
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08/18/17												
08/19/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 08/20/17 to 09/02/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
08/20/17												
08/21/17												
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09/01/17												
09/02/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 09/03/17 to 09/16/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
09/03/17												
09/04/17												
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09/16/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 09/17/17 to 09/30/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
09/17/17												
09/18/17												
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09/30/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 10/01/17 to 10/14/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
10/01/17												
10/02/17												
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SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 10/15/17 to 10/28/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
10/15/17												
10/16/17												
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10/28/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 10/29/17 to 11/11/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
10/29/17												
10/30/17												
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SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

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R. 2014
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PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 11/12/17 to 11/25/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
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11/13/17												
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SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
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PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 11/26/17 to 12/09/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
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12/09/17												
SubTotals Wk 2												
Total Hours												

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Service & Billing Code	Hours	Rate	Total
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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 12/10/17 to 12/23/17

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
12/10/17												
12/11/17												
12/12/17												
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SubTotals Wk 1												
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12/18/17												
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12/22/17												
12/23/17												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 12/24/17 to 01/06/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
12/24/17												
12/25/17												
12/26/17												
12/27/17												
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12/29/17												
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SubTotals Wk 1												
12/31/17												
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01/05/18												
01/06/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 01/07/18 to 01/20/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
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01/08/18												
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01/20/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 01/21/18 to 02/03/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
01/21/18												
01/22/18												
01/23/18												
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SubTotals Wk 1												
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02/03/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 02/04/18 to 02/17/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
02/04/18												
02/05/18												
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02/17/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 02/18/18 to 03/03/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
02/18/18												
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03/03/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 03/04/18 to 03/17/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
03/04/18												
03/05/18												
03/06/18												
03/07/18												
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03/17/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 03/18/18 to 03/31/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
03/18/18												
03/19/18												
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03/31/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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R. 2014
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PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 04/01/18 to 04/14/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
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SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
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PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 04/15/18 to 04/28/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
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SubTotals Wk 2												
Total Hours												

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PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 04/29/18 to 05/12/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
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SubTotals Wk 2												
Total Hours												

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*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 05/13/18 to 05/26/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
05/13/18												
05/14/18												
05/15/18												
05/16/18												
05/17/18												
05/18/18												
05/19/18												
SubTotals Wk 1												
05/20/18												
05/21/18												
05/22/18												
05/23/18												
05/24/18												
05/25/18												
05/26/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

*Documentation/Information Must Be **Legible** & Employees Are Responsible For Completing Service Documentation*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 05/27/18 to 06/09/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
05/27/18												
05/28/18												
05/29/18												
05/30/18												
05/31/18												
06/01/18												
06/02/18												
SubTotals Wk 1												
06/03/18												
06/04/18												
06/05/18												
06/06/18												
06/07/18												
06/08/18												
06/09/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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R. 2014
DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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Participant Name & ID #: _____ Employee Name & ID #: _____

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Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 06/10/18 to 06/23/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
06/10/18												
06/11/18												
06/12/18												
06/13/18												
06/14/18												
06/15/18												
06/16/18												
SubTotals Wk 1												
06/17/18												
06/18/18												
06/19/18												
06/20/18												
06/21/18												
06/22/18												
06/23/18												
SubTotals Wk 2												
Total Hours												

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
		TOTAL	

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PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

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Month Services Provided (MM/DD/YY):	

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period 06/24/18 to 07/07/18

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
06/24/18												
06/25/18												
06/26/18												
06/27/18												
06/28/18												
06/29/18												
06/30/18												
SubTotals Wk 1												
07/01/18												
07/02/18												
07/03/18												
07/04/18												
07/05/18												
07/06/18												
07/07/18												
SubTotals Wk 2												
Total Hours												

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Service & Billing Code	Hours	Rate	Total
		TOTAL	

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