



# Caregiver's Time sheets

**March 2020**

Employer Name (Member): \_\_\_\_\_

Phone: \_\_\_\_\_

Employee Name (Caregiver): \_\_\_\_\_

Phone: \_\_\_\_\_

Has the Employer's health changed?  Same  Declined  Improved Do you live with the member?  Yes  No  
 Were the Employer and/or Caregiver injured during anytime this month?  Yes  No  
 Was the Employer hospitalized during anytime this month?  Yes  No Date Admitted: \_\_\_\_\_ Discharged: \_\_\_\_\_

**YOU MUST CHECK THE BOXES OF ALL DUTIES PERFORMED (Drawing lines are not acceptable)**

YOU MUST CHECK THE BOXES OF ALL DUTIES PERFORMED (Drawing lines are not acceptable)													For Office Use Only
Day/Date	Meal Prep and /or Feeding	Bathing and/or Grooming	Dressing	Assist with Meds	Toileting	Mobility/ Transferring	Housework and/or Laundry	Errands and/or Shopping	Time In	Circle One	Time Out	Time Out	
<b>Week 1</b>													
Sun	1st									am pm		am pm	
Mon	2nd									am pm		am pm	
Tue	3rd									am pm		am pm	
Wed	4th									am pm		am pm	
Thurs	5th									am pm		am pm	
Fri	6th									am pm		am pm	
Sat	7th									am pm		am pm	
<b>Week 2</b>													
Sun	8th									am pm		am pm	
Mon	9th									am pm		am pm	
Tue	10th									am pm		am pm	
Wed	11th									am pm		am pm	
Thurs	12th									am pm		am pm	
Fri	13th									am pm		am pm	
Sat	14th									am pm		am pm	
<b>Week 3</b>													
Sun	15th									am pm		am pm	
Mon	16th									am pm		am pm	
Tue	17th									am pm		am pm	
Wed	18th									am pm		am pm	
Thurs	19th									am pm		am pm	
Fri	20th									am pm		am pm	
Sat	21st									am pm		am pm	
<b>Week 4</b>													
Sun	22nd									am pm		am pm	
Mon	23rd									am pm		am pm	
Tue	24th									am pm		am pm	
Wed	25th									am pm		am pm	
Thurs	26th									am pm		am pm	
Fri	27th									am pm		am pm	
Sat	28th									am pm		am pm	
<b>Week 5</b>													
Sun	29th									am pm		am pm	
Mon	30th									am pm		am pm	
Tue	31st									am pm		am pm	

Total:  

I confirm that the information above is accurate and true and does not include hours the employee did not, when the employer was hospitalize, and/or for services the employee did not provide. I understand that claiming hours not worked, when the employer was hospitalized, and/or for services that were not provided is Medicare/Medicaid fraud, and is a felony under law. I agree to allow Metro Solutions to deduct from subsequent earnings all overpayments issued to and received by the employee. I understand that all requirements must be met for payment to be authorized and paid. If the requirements are not met it will be the employer's responsibility to make payments their employee. I further understand that Metro Solutions cannot pay the employee more than the units approved by the employer's Intergrated Health Plan (ICO). I confirm the statements made in this document are accurate and true.

EMPLOYER SIGNATURE: \_\_\_\_\_  
 (Member)

Date: \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_  
 (Caregiver)

Date: \_\_\_\_\_

**For time sheet due dates, please refer to the Member/Caregiver Information Booklet**  
 Time sheets that are received after the due date will be processed within 7-10 business days of receipt.