Caregiver's Time sheets

METRO Solutions
Linking Funds to the Community

September 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)

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	For Office Use Only
Week 1														
Tue	**1st**										am pm		am pm	
Wed	**2nd**										am pm		am pm	
Thurs	**3rd**										am pm		am pm	
Fri	**4th**										am pm		am pm	
Sat	**5th**										am pm		am pm	
Week 2														
Sun	**6th**										am pm		am pm	
Mon	**7th**										am pm		am pm	
Tue	**8th**										am pm		am pm	
Wed	**9th**										am pm		am pm	
Thurs	**10th**										am pm		am pm	
Fri	**11th**										am pm		am pm	
Sat	**12th**										am pm		am pm	
Week 3														
Sun	**13th**										am pm		am pm	
Mon	**14th**										am pm		am pm	
Tue	**15th**										am pm		am pm	
Wed	**16th**										am pm		am pm	
Thurs	**17th**										am pm		am pm	
Fri	**18th**										am pm		am pm	
Sat	**19th**										am pm		am pm	
Week 4														
Sun	**20th**										am pm		am pm	
Mon	**21st**										am pm		am pm	
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Week 5														
Sun	**27th**										am pm		am pm	
Mon	**28th**										am pm		am pm	
Tue	**29th**										am pm		am pm	
Wed	**30th**										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 provieded 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 requiremets are not met it will the employer's responsiblity 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:_____ Date:_____
(Member)

EMPLOYEE SIGNATURE:_____ Date:_____
(Caregiver)

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.

18000 West 9 Mile Rd. - Suite 360 - Southfield, MI 48075 - Phone: (313) 963-8383 -Fax: (313) 488-0563 - Email: fax@metrosolutions.us

Caregiver's Time sheets

METRO Solutions
Linking Funds to the Community

October 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)

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EMPLOYER SIGNATURE:_____ Date:_____
(Member)

EMPLOYEE SIGNATURE:_____ Date:_____
(Caregiver)

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Caregiver's Time sheets

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November 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)

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EMPLOYER SIGNATURE:_____ Date:_____

(Member)

EMPLOYEE SIGNATURE:_____ Date:_____

(Caregiver)

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Caregiver's Time sheets

METRO Solutions
Linking Funds to the Community

December 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)

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(Member)

EMPLOYEE SIGNATURE:_____ Date:_____
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