March 2020

The Senior Alliance (TSA)

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:________________ Date 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	Circle One	Member Initials	For Office Use Only
Week 1															Total Units
Sun	1st										am pm		am pm		
Mon	2nd										am pm		am pm		
Tues	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		
Week 2															
Sun	8th										am pm		am pm		
Mon	9th										am pm		am pm		
Tues	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		
Week 3															
Sun	15th										am pm		am pm		
Mon	16th										am pm		am pm		
Tues	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		
Week 4															
Sun	22nd										am pm		am pm		
Mon	23rd										am pm		am pm		
Tues	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		
Week 5															
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. <u>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.</u> 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.

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