



The Senior Alliance (TSA)

September 2020

Employer Name (Member): _____

Phone: _____

Employee Name (Caregiver): _____

Phone: _____

Has the Employer's health changed? Same Declined Improved 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														
Tues	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		
Tues	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		
Tues	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		
Tue	22nd									am pm		am pm		
Wed	23rd									am pm		am pm		
Thu	24th									am pm		am pm		
Fri	25th									am pm		am pm		
Sat	26th									am pm		am pm		
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 hospitalized, 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 to their employee. I further understand that Metro Solutions cannot pay the employee more than the units approved by the employer's Integrated 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.
 18000 West 9 Mile Rd. - Suite 360 - Southfield, MI 48075 - Phone: (313) 963-8383 - Fax: (313) 488-0563 - Email: fax@metrosolutions.us



The Senior Alliance (TSA)

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: _____ 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	
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Week 2															
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Fri	30th									am	pm		am	pm	
Sat	31st									am	pm		am	pm	

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EMPLOYER SIGNATURE: _____
(Member)

Date: _____

EMPLOYEE SIGNATURE: _____
(Caregiver)

Date: _____

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The Senior Alliance (TSA)

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: _____ Date Discharged: _____

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EMPLOYER SIGNATURE: _____
(Member)

Date: _____

EMPLOYEE SIGNATURE: _____
(Caregiver)

Date: _____

For time sheet due dates, please refer to the Member/Caregiver Information Booklet
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The Senior Alliance (TSA)

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: _____ Date Discharged: _____

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

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EMPLOYER SIGNATURE: _____
(Member)

Date: _____

EMPLOYEE SIGNATURE: _____
(Caregiver)

Date: _____

For time sheet due dates, please refer to the Member/Caregiver Information Booklet

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