CAREGIVER MONTHLY TIME SHEET

For month of: _____
(MONTH/YEAR)

Employer *(Member)* **:** _____ **Phone:** _____
(PLEASE PRINT)

Employee *(Caregiver)* : _____ **Phone:** _____
(PLEASE PRINT)

Was the Employer hospitalized during anytime this month? ☐ **Yes** ☐ **No**

Does the caregiver live with the member? ☐ Yes ☐ No

Date Admitted: _____ **Date Discharged**: _____

	Day	Date	Meal Prep/ Feeding	Bathing/Grooming	Dressing	Housekeeping	Assit w/Meds	Toileting	Mobility/Transferring	Errands/ Shopping	*1st SHIFT* Time Out	*1st SHIFT* Time Out	*1st SHIFT* Circle One	*2nd SHIFT* Time Out	*2nd SHIFT* Time Out	*2nd SHIFT* Circle One	FOR OFFICE USE ONLY *(Total Units)*
			Check the boxes of all duties performed *(Drawing lines are not acceptable)*														
Week 1	Sun												am pm			am pm	
	Mon												am pm			am pm	
	Tue												am pm			am pm	
	Wed												am pm			am pm	
	Thu												am pm			am pm	
	Fri												am pm			am pm	
	Sat												am pm			am pm	
Week 2	Sun												am pm			am pm	
	Mon												am pm			am pm	
	Tue												am pm			am pm	
	Wed												am pm			am pm	
	Thu												am pm			am pm	
	Fri												am pm			am pm	
	Sat												am pm			am pm	
Week 3	Sun												am pm			am pm	
	Mon												am pm			am pm	
	Tue												am pm			am pm	
	Wed												am pm			am pm	
	Thu												am pm			am pm	
	Fri												am pm			am pm	
	Sat												am pm			am pm	
Week 4	Sun												am pm			am pm	
	Mon												am pm			am pm	
	Tue												am pm			am pm	
	Wed												am pm			am pm	
	Thu												am pm			am pm	
	Fri												am pm			am pm	
	Sat												am pm			am pm	
Week 5	Sun												am pm			am pm	
	Mon												am pm			am pm	
	Tue												am pm			am pm	
	Wed												am pm			am pm	
	Thu												am pm			am pm	
	Fri												am pm			am pm	
	Sat												am pm			am pm	
															Total:		

By signing below, I certify that the information above is accurate and true and does not include hours the employee did not work 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 HCBS to deduct from subsequent earnings all overpayments issued to and received by the employee.** I further understand that Metro HCBS cannot pay the employee more than the total units authorized by the Waiver Agent and/or the employer's Health Insurance Provider.

Employer Signature: _____ **Date:** _____

Employee Signature: _____ **Date:** _____

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