



Caregiver's Time sheets

July 2021

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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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	
Week 1													Total Units
Thu	1st									am pm		am pm	
Fri	2nd									am pm		am pm	
Sat	3rd									am pm		am pm	
Week 2													
Sun	4th									am pm		am pm	
Mon	5th									am pm		am pm	
Tue	6th									am pm		am pm	
Wed	7th									am pm		am pm	
Thurs	8th									am pm		am pm	
Fri	9th									am pm		am pm	
Sat	10th									am pm		am pm	
Week 3													
Sun	11th									am pm		am pm	
Mon	12th									am pm		am pm	
Tue	13th									am pm		am pm	
Wed	14th									am pm		am pm	
Thurs	15th									am pm		am pm	
Fri	16th									am pm		am pm	
Sat	17th									am pm		am pm	
Week 4													
Sun	18th									am pm		am pm	
Mon	19th									am pm		am pm	
Tue	20th									am pm		am pm	
Wed	21st									am pm		am pm	
Thurs	22nd									am pm		am pm	
Fri	23rd									am pm		am pm	
Sat	24th									am pm		am pm	
Week 5													
Sun	25th									am pm		am pm	
Mon	26th									am pm		am pm	
Tue	27th									am pm		am pm	
Wed	28th									am pm		am pm	
Thu	29th									am pm		am pm	
Fri	30th									am pm		am pm	
Sat	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 to 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.