



Caregiver's Time sheets

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