Caregiver's Time sheets

September 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)

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