The Senior Alliance (TSA)

Employer Name *(Member):* _____ **Phone:** _____

Employee Name *(Caregiver):* _____ **Phone:** _____

Has the Employer's health changed? ☐ Same ☐ Declinec ☐ 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:_____

1st Week Pay Period Ending Date: _____/_____/_____

YOU MUST CHECK THE BOXES OF ALL DUTIES PERFORMED (Drawing lines are not acceptable)														
Week 1 *(Please fill in the 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	Initials	For Office
Sun: ____/____/____										am pm		am pm		
Mon: ____/____/____										am pm		am pm		
Tue: ____/____/____										am pm		am pm		
Wed: ____/____/____										am pm		am pm		
Thur: ____/____/____										am pm		am pm		
Fri: ____/____/____										am pm		am pm		
Sat: ____/____/____										am pm		am pm		
												Weekly Total:		

2nd Week Pay Period Ending Date: _____/_____/_____

YOU MUST CHECK THE BOXES OF ALL DUTIES PERFORMED (Drawing lines are not acceptable)														
Week 2 *(Please fill in the 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	Initials	For Office
Sun: ____/____/____										am pm		am pm		
Mon: ____/____/____										am pm		am pm		
Tue: ____/____/____										am pm		am pm		
Wed: ____/____/____										am pm		am pm		
Thur: ____/____/____										am pm		am pm		
Fri: ____/____/____										am pm		am pm		
Sat: ____/____/____										am pm		am pm		
												Weekly Total:		

I confirm that the information above is accurate and true and does not include hours the employee did not work 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 the 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

Payments for time sheets that are received after the due date may be delayed

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