Self Directed Community Habilitation
Employee Time Sheet/Daily Service Record

SD Community Habilitation Agency:	**The Center for Family Support Self Directed Services**
Participant's Medicaid CIN:	Participant's Name:
Employee's Name:	Employee's Title: Habilitation Specialist - **Mentor**
Pay Period:	Primary Service Location:

Valued Outcomes: (Enter the participant's valued outcomes and the supports and services associated with each outcome.)

A)
1.
2.

B)
1.
2.
3.

C)
1.
2.
3.
4.

D)
1.
2.
3.
4.
5.
6.
7.

E)
1.
2)
3.
4.
5.

Put your initials in the "Initials" box for each date a service was provided. This is your attestation that service was provided on that day.

Day	Date: M/D/Y	Start Time AM/PM	End Time AM/PM	Tot Hrs Charged	Face-to-Face (Y/N)	Specify the Staff Action Provided in Support of a Valued Outcome (service locations may be noted) Also note PTO	Initials
Sat							
Sun							
Mon							
Tues							
Wed							
Thurs							
Fri							
Total hours worked this week:							

Day	Date: Mo/Day	Start Time AM/PM	End Time AM/PM	Tot Hrs Charged	Face-to-Face (Y/N)	Specify the Staff Action Provided in Support of a Valued Outcome (service locations may be noted) Also note PTO	Initials
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Sun							
Mon							
Tues							
Wed							
Thurs							
Fri							
Total hours worked this week:							

*****Signing and submitting false information may lead to a charge of Medicaid fraud.*****

Signature of Employee: Initials: Date:

Signature of Participant/Representative: Date:

Participant: Original to FI

For FIS Use Only ----- Payroll Authorization _____ **(FI Initials) ……. (Date)** Total Hours Paid …….. Total Hours PTO ……