

Payroll Period: ___/___/___ to ___/___/___

Eclectic Healthcare LLC. Personal Care Attendant Timesheet

Employer Name: _____ Attendant Name: _____

	MON	TUES	WED	THUR	FRI	SAT	SUN
DATES	/	/	/	/	/	/	/
TIME-IN	AM PM						
TIME-OUT	AM PM						
PARTICIPANT INITIALS							
ATTENDANTS INITIALS							
TIME-IN	AM PM						
TIME-OUT	AM PM						
DAILY TOTAL							
	HRS MIN						

Check box if hospitalized	<input type="checkbox"/> Hosp						
TASKS	MON	TUES	WED	THUR	FRI	SAT	SUN
Personal Care							
Toileting							
Health							
Housekeeping							
Meal							
Transportation							

Note: Signature verifies that all dates and times entered are true and accurate. I understand that my attendant cannot be paid for time I am in the hospital. Falsification of timesheets is Medicaid Fraud. Eclectic Healthcare Services LLC. procedure is to report all suspected fraud to the Missouri Department of Health and Senior Services. If Fraud is suspected, Your CDS services will be suspended immediately.....TIME SLIPS ARE DUE EVERY MONDAY BY 4 P.M. PLEASE YOU ONE COLOR INK.

Employee Signature: _____ Date: _____

Attendant Signature: _____ Date: _____

Please Circle One of the following: I Was In The Hospital? YES OR NO I WAS Not In The Hospital? YES OR NO

If Hospitalized Please Provide Dates: ___/___/___ to ___/___/___