

ARIZONA SDAC TIMESHEET

For the week of service, timesheets are due the following Monday by Midnight if faxed or dropped off and postmarked by Monday if by mail. Due to the timing of the payroll cycle, late timesheets may result in late pay.

Attendant Care

Worker (ACW) Name: _____



Office Use Only

C:Late

C:IOT

Member Name: _____

Please print clearly!

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Time In							
Time Out							
Time In							
Time Out							
Time In							
Time Out							
Total Time Worked							

NOTE: Timesheets must be signed AFTER the work is completed. Advance timesheets will not be accepted.

Total Weekly Hours: _____

Attendant Care Worker: I certify that I have worked the above hours listed for this Member and that services were provided in accordance with the ACW Schedule/Member Care Plan. I understand that falsification of this timesheet is considered Medicaid Fraud and may result in dismissal from the program and criminal prosecution.

_____/_____/_____
ACW Signature *Date* *Phone Number*

Member: Please initial to verify each statement for this time period [if any are "yes", please provide dates and times]:

- _____ 1. I was admitted to the hospital
 Dates and times in hospital: From: ____/____/____ at ____:____ am/pm
 To: ____/____/____ at ____:____ am/pm
- _____ 2. I **DID NOT** receive all my Attendant Care services as scheduled.
 Date(s) and times of missed services: ____/____/____ at ____:____ am/pm
 ____/____/____ at ____:____ am/pm

I certify that the above logged the hours listed for this ACW are accurate and that services were provided in accordance with the Attendant Care Worker Schedule/Member Care Plan. I understand that falsification of this timesheet is considered Medicaid Fraud and may result in dismissal from the program and criminal prosecution.

Please send extra timesheets

Timesheets can also be found at www.consumerdirectonline.net

_____/_____/_____
Member Signature *Date*