DSP/Respite Provider TIMESHEET INSTRUCTIONS

1. Provider - name of provider filling out timesheet
2. Mailing Address - address of provider (include city, state, and zip)
3. Month/Year - month and year work was performed
4. Phone - phone number of the provider
5. Date - record dates in this column for this pay period
6. Start Time - time started working with individual
7. End Time - time ended working with individual
8. # of Hrs. - total number of hours worked for that day (this must equal the hours by individual)
9. DIRECT SERVICE HOURS - In the blank boxes, write the initials of the individuals and duties you are providing. There is a key on the bottom of the timesheet for abbreviation. For Example: KaBr-HA – 1st two letters of first name and 1st two letters of last name. Under the individual's initials, record the hours with that individual.
10. Total the # of Hrs. column and the Direct Service Hours column
11. Key - HA: DSP
    HM: Homemaker
    C: Companion
    R: Respite
    CT: CAT (Children's Autism Trainer)
12. Provider's signature - provider signs timesheet certifying the hours recorded are accurate
13. Supervisor Signature- signed by supervisor after review
14. Employees must attach appropriate data sheets for individuals if needed
15. For office use only - this is used by Business Manager when processing payroll. Timesheet is to be turned in to your supervisor the last working day of the pay period. Staff in outlying areas can either fax, email, or mail (regular mail is 3-5 business days, there is not a guarantee that timesheets will reach the MC DEAP office in time to process it for payroll).

				Direct Service Hours (Individual initials in columns)					
Date	**Start Time**	**End Time**	**# of Hrs.**	**KaBr-HA**	**KaBr-HM**	**ShTa-C**	**ViCl-R**	**KiBe-CT**	**Training**
8/1/2018	8:00 AM	12:00 PM	4.00	4.00					
8/2/2018	1:00 PM	5:00 PM	4.00	2.00	2.00				
8/5/2018	8:00 AM	10:30 AM	2.50			2.50			
8/5/2018	3:00 PM	5:15 PM	2.25				2.25		
8/6/2018	8:00 AM	5:00 PM	9.00					9.00	
8/8/2018	8:00 AM	12:45 PM	4.75					3.75	1.00
		Total	26.50	6.00	2.00	2.50	2.25	12.75	1.00

I certify that the contents as written are accurate and data/activity sheets are attached. Provider signature is required for payment.

_____

Provider's Signature Date

_____

Supervisor Signature Date

_____

Supervisor Signature Date

KEY:
HA - DSP
HM - Homemaker
C - Companion
R - Respite
CT - CAT

For Office use only:

REG _____

HW _____

TOTAL _____

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