ATTENDENT SERVICES MAINE
asm
Fiscal Intermediary

MaineCare - Participant Directed Option Attendant Timesheet
Section 19 - HCB & EAWD
2017

Consumer's name (print) _____

Attendant's name (print) _____

Pay Period Beginning:

Week 1

	Date	Time In	Time Out	Time In	Time Out	Time In	Time Out	Hours
Sun								
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
							Weekly Totals:	

Week 2

	Date	Time In	Time Out	Time In	Time Out	Time In	Time Out	Hours
Sun								
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
							Weekly Totals:	

Total hours worked: _____

Daily Tasks Completed (Check all that apply)

Transfers/Mobility		Dressing	
Meal Prep/Eating		Errands	
Household Tasks		Bowel/Bladder	
Bathing/Hygiene			

For Official use only

I certify that the above information is true, accurate and complete. I certify that my Maine Care Coverage is in effect for this time period, and am not billing while in a hospital or a nursing facility. I certify that the Attendant is NOT a family member*, or Consumer Representative. I understand that payments are from Federal and State funds. Any false statements will be prosecuted under applicable laws. * A "family member" means a spouse of the recipient, the parents or step-parents of a minor child, or a legally responsible relative.

Consumer/**Rep** Signature: _____ **Date:** _____

New Phone #: _____

Attendant Signature: _____ **Date:** _____

New Phone #: _____