

Employee Time Sheet / Service Delivery Record

EAK Good Neighbor

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CLIENT NAME	
EMPLOYER/DR NAME	
EMPLOYEE NAME	

Begin _____ End _____

Program (please circle) STAR Kids (PCS) STAR Plus PHC Waiver DSHS PCS
Type of Service (please circle) HAB PAS PAS/HAB Respite Protective Supervision

DATE	Day	Time In	Time Out	Time In	Time Out	Reason Employee was unable to clock in/out?
	Sunday					
	Monday					
	Tuesday					
	Wednesday					
	Thursday					
	Friday					
	Saturday					
	Sunday					
	Monday					
	Tuesday					
	Wednesday					
	Thursday					
	Friday					
	Saturday					

Note: The employee is required to clock-in and clock-out of each scheduled shift using an approved EVV method.
 Option 2: This form is only used to submit missing time or to make corrections to clock in/out time.
 Option 3: This form is used to submit missing time or to make corrections to time AND to verify clock in/out time.

Employee Signature _____ Date: _____

Employer/DR Signature _____ Date: _____

The Employer/DR and Employee certify that these are the true and correct hours worked, all services provided were according to the current tasks authorized and all services were NOT provided while the client was in the hospital, nursing home or other healthcare facility. The FMSA will confirm my approval of the time my CDS employee worked in the EVV system. I delegate the performance of the EVV visit maintenance to the FMSA.

By signing the time sheet, Employer/DR and Employee understand that falsification of this time sheet is considered Medicaid fraud and could result in dismissal from the program/services and criminal prosecution.