Service Delivery Log with Written Narrative/Written Summary

Program	Participant Name
Pay Period	Employer Name
Service Provider Name	Service Type ☐ PAS ☐ SHL ☐ Respite ☐ Community Support ☐ Residential Habilitation ☐ Other _____

Service Date	Time In (AM or PM)	Time Out (AM or PM)	Time In (AM or PM)	Time Out (AM or PM)	Total Hours	Place of Service	Written Narrative Continue narrative on next page, if needed.
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
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	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
	:	:	:	:			
				Total Hours			

The employer cannot submit a time sheet to the Financial Management Services Agency (FMSA) for time worked by the employee while the individual was in the hospital.
The employee and employer certify that the information provided above is complete and accurate and understand that submitting a false or fraudulent time sheet could result in a Medicaid fraud referral.

_____ Signature — Service Provider

_____ Date

_____ Signature — Employer or Designated Representative (DR)

_____ Date

Service Type:

_____ Hours Reg at $ _____ per hour _____ Hours Sick

_____ Hours OT at $ _____ per hour _____ Hours Holiday

_____ Hours Vacation _____ Bonus

☐ Other

FMSA Use Only

Time sheet: ☐ Acceptable ☐ Unacceptable ☐ Return to employer

Notes: _____ **FMSA:** _____

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Service Date	Place of Service	Written Narrative

_____ _____ _____ _____
Signature — Service Provider | Date | Signature — Employer or DR | Date