

CONSUMER DIRECTED PERSONAL ASSISTANT PROGRAM

CARE GIVER TIME SHEET

AIM 271 East First St. Corning, NY 14830

Phone: 962-8225 Fax 962-2592

Consumer: _____

Personal Assistant: _____

TIME SHEET DUE DATE: _____

DATE	START TIME A.M./P.M.	END TIME A.M./P.M.	TOTAL	CONSUMER Signature		AIDE Signature
					I certify that the hours were worked and all contracted services were rendered. I understand that this timesheet is a legal document and that submitting inaccurate information is Medicaid Fraud and will cause immediate removal from the CDPAS Program.	

Total Hours Worked: _____

**Timesheet will not be accepted unless each line is signed by the Consumer AND the Assistant*
***Timesheets with missing information will be returned to the Consumer for corrections*