DOCUMENTATION OF SERVICES DELIVERED - CDS

***You may email timesheets to cds@cdsintexas.com or reference the pay schedule for the appropriate fax number to send in your timesheet**

CDS consumer directed services in Texas

Consumer Name:	
Employer Name:	
Service Provider Name:	

Program Selection

___CLASS ___PHC ___DBMD ___STAR Plus ___HCS ___ STAR Kids ___Private Pay

Type of Service

___ HAB ___PAS ___PAS/HAB ___RESPITE ___LVN/RN ___Protective Supervision ___Transportation

Tasks were performed according to the Plan of Care? ☐ **(Please check box)**

Pay Period Number:

****USE 24 HOUR TIME: 8:00 A.M OR 20:00 FOR 8:00 P.M.**

DATE	DAY	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL TIME	COMMENTS / NARRATIVE

Total Payroll / Pay Period Hours Delivered:

Service:___________________

_________ Hours Vacation

_________ Hours Sick

_________ Hours Holiday

_________ Bonus

_________ Other ________

Service:___________________

_________ Hours Vacation

_________ Hours Sick

_________ Hours Holiday

_________ Bonus

_________ Other _________

FMSA Agency Only

Date Processed:

By Whom:

Was the consumer hospitalized or in an medical care facility during this pay period? Please list dates:_________________

Employer and Employee here by certify that the work hours listed above are accurate, that the services provided are in accordance with the current tasks authorized and the services were NOT provided while the consumer was in the hospital, nursing home, or the Medicaid-reimbursed healthcare facility. I understand that falsification of this time sheet is considered Medicaid Fraud, and may result in dismissal from the program and criminal prosecution.

FMSA Notes	Timesheet Tasks
	Acceptable: ______________
	Unacceptable: ______________
	Notified Employer: ______________

Service Provider Signature **Date**

Employer or DR Signature **Date**