

Utah Division of Services for People with Disabilities Special Compensated Caregiver Timesheet (UT DSPD)



 EMPLOYEE NAME (LAST NAME, FIRST NAME)

 EMPLOYEE ID

 CLIENT NAME (LAST NAME, FIRST NAME)

 CLIENT ID

By signing this form, I attest that services were delivered and received consistent with the Individual Service Plan and I have rendered and/or approved this payment request in accordance with the Program regulations. I understand that payment and satisfaction of this claim may be from Federal and State funds, and that I may be prosecuted under applicable Federal or State laws for any false claims, statements, or documents, or concealment of a material fact. Any misuse of funds may result in being fined or penalized, including but not limited to the repayment of claim. Collection costs or legal fees will be my responsibility.

 Caregiver Signature (required)

 Date (required)

 Employer Signature (required)

 Date (required)

	SERVICE DATE (MM/DD/YY)	CHECK IN TIME	CHECK OUT TIME	SERVICE
A	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				
B	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				
C	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				
D	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				
E	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				
F	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				
G	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				
H	____ / ____ / ____	____ : ____ ○ AM ○ PM	____ : ____ ○ AM ○ PM	____
*Comment : _____				

***The entire time sheet will be rejected if service lines are entered without having a corresponding completed comment.**