Utah Salt Lake County Time Sheet

18672

EMPLOYEE NAME (LAST NAME, FIRST NAME)

EMPLOYEE ID

PARTICIPANT NAME (LAST NAME, FIRST NAME)

PARTICIPANT ID

P C

Service Code

By signing this form, I attest that services were delivered and received consistent with the Comprehensive Care Plan. The Participant was NOT in a hospital, nursing home, or institution 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 my repayment of claim.

Employee Signature Date

Employer Signature Date

Case Manager

Program

SLCA Signature Date

Service Date			Start Time			End Time			# Hours
Month	Day	Year	Hour	Minute		Hour	Minute		
/	/		:		AM PM	:		AM PM	

Total

Return by faxing WITHOUT COVERSHEET to (385) 468-3186 or mailing to:
Salt Lake County Aging Services, Attn: Community Care Transition Program, 2001 South State #S-1500, Salt Lake City, UT 84114-4575

04/26/18