Time Entry Change Form

The State requires written approval from the Participant for the claim to be corrected.
This form is for incomplete shifts.
No Full Shifts can be added

Participant Name: _____

Participant Medicaid ID #:_____

DSW Name:_____

Worker ID#: _____

Date of Service: _____

Clock In Time: _____

Clock Out Time: _____

Activity Codes: _____

Reason for Correction: _____

_____

Worker Signature: _____

Participant/Guardian Signature: _____

*Note: If the DSW is the parent or Legal Guardian, the Designated Representative or someone else must sign and verify the Time Entry Change Form.

I certify by submitting and signing this form that I understand the following: As the self-directing Participant/Employer or Designated Representative, I assume all responsibility of employment of Direct Support Workers (DSWs), including assuring DSW work hours are submitted to the KS Authenticare system and are within the Participant/Employer's specific Integrated Service Plan (ISP)). I understand Helpers, Inc. policies require time changes to be submitted within 24 hours of the date needing correction to ensure timely payment, that I may only submit a maximum of five (5) time changes per month per Participant/Employer, and that hours worked that exceed the ISP are not billable to my Managed Care Organization and therefore will not be billed or paid by Helpers, Inc.

Fax or scan and email the form to help@helpersinc.org within 24 hours of service.

15540 Pflumm Road
Olathe, KS 66062
Help@helpersinc.org
Fax: (913) 322-7250