

Consumer Directed Services
Service Delivery Log with Written Narrative/Written Summary

Program	Participant Name
Pay Period	Employer Name

Service Provider Name	Service Type <input type="checkbox"/> PAS <input type="checkbox"/> SHL <input type="checkbox"/> Respite <input type="checkbox"/> Community Support <input type="checkbox"/> Residential Habilitation <input type="checkbox"/> Other _____
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Service Date	Time In (AM or PM)	Time Out (AM or PM)	Time In (AM or PM)	Time Out (AM or PM)	Total Hours	Place of Service	Written Narrative <small>Continue narrative on next page, if needed.</small>
Total Hours							

The employer cannot submit a time sheet to the Financial Management Services Agency (FMSA) for time worked by the employee while the individual was in the hospital.
 The employee and employer certify that the information provided above is complete and accurate and understand that submitting a false or fraudulent time sheet could result in a Medicaid fraud referral.

Signature — Service Provider	Date	Signature — Employer or Designated Representative (DR)	Date
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Service Type: _____ Hours Reg at _____ per hour _____ Hours Sick _____ Hours OT at _____ per hour _____ Hours Holiday _____ Hours Vacation _____ Bonus <input type="checkbox"/> Other	FMSA Use Only
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Time sheet: Acceptable Unacceptable Return to employer

Notes: _____ **FMSA:** _____