VETERAN DIRECTED CARE TIMESHEET

Fax: 636-447-0341 Email: vipeditslips@dcil.org

Pay Period Begins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pay Period Ends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Veteran Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- |
| **Date mo/day/yr** | **Time IN** | **AM/PM** | **Time OUT** | **AM/PM** | **Total Hrs** | **Tasks Completed** |
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Page \_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_ Total: \_\_\_\_\_\_\_\_\_ \*cannot claim hours while individual is in the hospital or other medical care facility

 Check if timesheet reflects approved hours. Contact your case manager to explain any overage. Hours worked over approval, will be billed to Veteran/Authorized Representative.

Veteran’s/AR Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Submission of falsified timesheet constitutes fraud and is a felony punishable by fine and/or imprisonment. With my signature, I certify timesheet accuracy.