OPWDD Self Direction Self Hired

**Staff Time and Reimbursement Form**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name |  | | Payroll Period | |  | | to | |  |
| Participant Name |  | CIN: | |  | | TABS: | |  | |

**Hours Worked/Billed:** *all hours must be reflected in the corresponding case note.*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Day** | **Date** | | **Time In** | **Time Out** | **CH**  **Total** | **SEMP**  **Total** | **Respite**  **Total** | **PTO**  **Total Used** | **Non-Face to Face Time** | **Staff Initials** |
| **Monday** |  | |  |  |  |  |  |  |  |  |
| **Tuesday** |  | |  |  |  |  |  |  |  |  |
| **Wednesday** |  | |  |  |  |  |  |  |  |  |
| **Thursday** |  | |  |  |  |  |  |  |  |  |
| **Friday** |  | |  |  |  |  |  |  |  |  |
| **Saturday** |  | |  |  |  |  |  |  |  |  |
| **Sunday** |  | |  |  |  |  |  |  |  |  |
| **Monday** |  | |  |  |  |  |  |  |  |  |
| **Tuesday** |  | |  |  |  |  |  |  |  |  |
| **Wednesday** |  | |  |  |  |  |  |  |  |  |
| **Thursday** |  | |  |  |  |  |  |  |  |  |
| **Friday** |  | |  |  |  |  |  |  |  |  |
| **Saturday** |  | |  |  |  |  |  |  |  |  |
| **Sunday** |  | |  |  |  |  |  |  |  |  |
| **Bi-Weekly Total:** | |  | | | | | | | | |

**Staffing Reimbursements:** *All reimbursements must be reflected in the corresponding case note, receipts must be attached***.**

|  |  |  |
| --- | --- | --- |
| **Date** | **Total** | **Purpose of Expense** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Total: $**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Paid Neighbor** | Daily Rate: | **$ .** | # of Days On-Call |  | Total: | $ . |

**Signing and submitting false information may be considered Medicaid fraud. If you suspect Medicaid fraud, please report it immediately to Christine Cerro (518) 798-2972 ext 303. By signing below, you are attesting that information provided is accurate and that you have not witnessed abuse or neglect. Abuse or Neglect must be immediately stopped and reported to authorities and then (518) 798-2972 Christine Cerro ext 303 or Melissa McAleer ext. 305**

OPWDD Self Direction Self Hired

**Staff Mileage Reimbursement Form**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name |  | Payroll Period | | |  | | to | |  | |
| Participant Name |  | | CIN: |  | | TABS: | |  | | |
| **Total Mileage** | | | | | |  | | **.50** | |  |
| (Miles) | | (Per Mile) | | (Total) |

**Staffing Mileage:** *All mileage must be reflected in the corresponding case note***.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Starting Address**  **(full address)** | **Destination(s)**  **(full addresses)** | **Total Miles** | **Purpose**  **Check the appropriate reason** |
| Monday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
| Tuesday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
| Wednesday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
| Thursday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |
| Friday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |
|  |
| Saturday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |
|  |
| Sunday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |

OPWDD Self Direction Self Hired

**Staff Mileage Reimbursement Form**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name |  | Payroll Period | | |  | | to | |  |
| Participant Name |  | | CIN: |  | | TABS: | |  | |

**Staffing Mileage:** *All mileage must be reflected in the corresponding case note***.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Starting Address**  **(full address)** | **Destination(s)**  **(full addresses)** | **Total Miles** | **Purpose**  **Check the appropriate reason** |
| Monday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
| Tuesday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
| Wednesday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
| Thursday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |
| Friday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |
|  |
| Saturday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |
|  |
| Sunday  \_\_\_\_\_\_\_ |  |  |  | **Medical**  **Personal Use**  **Valued Outcome** |
|  |
|  |
|  |
|  |
|  |