

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES

ACQUIRED BRAIN INJURY (ABI)  
INVOICE AND TIME SHEET

<b>FIDUCIARY USE ONLY</b>	
Diagnosis Code:	_____
Date Received:	___/___/___
Date Returned:	___/___/___
Date Billed:	___/___/___

**PART I. - PROVIDER/PARTICIPANT INFORMATION**

Provider/Agency Name (First, Middle, Last)		Employee(s) Who Provided Service	
Address		Provider Type and ID (Check One) <input type="checkbox"/> AGENCY - enter FEIN _____ <input type="checkbox"/> PRIVATE - enter SSN ___/___/___	
Waiver Participant Name (First, Middle, Last)		Participant Medicaid ID Number	Provider Telephone #
		0   0	_____-_____-_____

**PART II. - INVOICE (To be completed by all providers)**

Date of Service FROM			Date of Service TO			Place of Service	Svs Type	Service Description	Procedure Code	Diagnosis Code	Days or Units	Charges \$
M	D	Y	M	D	Y							
							9					\$
							9					\$
							9					\$
							9					\$
							9					\$
<b>TOTAL</b>											\$	

**PART III. - TIME SHEET (Complete this time sheet only if you are a provider for whom the fiduciary agent will be handling FICA, FUTA, etc.) IF YOU ARE REQUIRED TO COMPLETE THIS TIME SHEET, YOU MUST OBTAIN THE WAIVER PARTICIPANT'S SIGNATURE BELOW.**

Day	Date Mo/Day/Yr	Time IN	Time OUT	Time IN	Time OUT	Time IN	Time OUT	Total Hours for Day
Mon								
Tues								
Wed								
Thur								
Fri								
Sat								
Sun								
<b>TOTAL</b>								

Day	Date Mo/Day/Yr	Time IN	Time OUT	Time IN	Time OUT	Time IN	Time OUT	Total Hours for Day
Mon								
Tues								
Wed								
Thur								
Fri								
Sat								
Sun								
<b>TOTAL</b>								

I certify that I or the individual(s) named above performed the stated ABI waiver services in accordance with the participant's approved plan.

Provider Name (Printed) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Waiver Participant Name (Printed) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_