

**CONNECTICUT HOME CARE PROGRAM FOR ELDERLY
STATE-FUNDED PCA PILOT PROGRAM
INVOICE AND TIME SHEET**

FIDUCIARY USE ONLY

Date Received: ___ / ___ / ___
Date Returned: ___ / ___ / ___
Date Billed: ___ / ___ / ___

PART I. - PROVIDER/PARTICIPANT INFORMATION

Private 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 PROVIDER - enter SSN ____/____/____	
Pilot Participant Name (First, Middle, Last)		Participant Medicaid ID Number 0 0	Provider of PCA Telephone # ____-____-____

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

Date of Service FROM			Date of Service TO			Place of Service	Svs Type	Service Description	Days	Charges \$
M	D	Y	M	D	Y					
							9			\$
							9			\$
							9			\$
							9			\$
							9			\$
TOTAL										\$

PART III. - TIME SHEET (YOU ARE REQUIRED TO COMPLETE THIS TIME SHEET AND YOU MUST OBTAIN THE 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
Sat								
Sun								
Mon								
Tues								
Wed								
Thur								
Fri								
TOTAL								

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

I certify that I or the individual(s) named above performed the stated PCA State-Funded services in accordance with the participant's approved plan.

Personal Care Assistant Name (Printed) _____

Signature _____

Date _____

Pilot Participant Name (Printed) _____

Signature _____

Date _____