W-1574
(New 10/00)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

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

MFP

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)* ☐ AGENCY - enter FEIN __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ 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*

Part 1: Fiduciary Copy Part 2: Participant Copy Part 3: Provider Copy