Time Sheet Documentation for Manual Electronic Visit Verification (EVV) Entries/Edits

Keystone First
Community HealthChoices

Agency name:	TIN and Provider ID:
Direct care worker name:	Last 4 digits of SSN:
Participant name:	Medicaid ID:
Location of service:	

Date	Start time	End time	Start time	End time	Total hours worked	Services provided based on individual plans of care

Participant signature:	Date:
Provider signature and agency position:	Date:
I, the undersigned Direct Care Worker, attest that I provided Personal Assistance Services, as described above, to the Participant listed on the time sheet above, and that the hours are true and correct.	
Direct Care Worker signature:	Date:

Note: **All** sections of the time sheet must be completed and signed by the Direct Care Worker, Participant, and Agency Designee. By signing in the designated area(s) above, you are confirming that the hours shown and the services provided were performed by the Direct Care Worker whose name appears on the time sheet.
Do not sign blank time and activity sheets.

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