INVOICE FOR PAYMENT

PERIOD ENDING DATE* _____
(ALWAYS SUNDAY)

SEND TO: AFFILIATED HOME CARE OF PUTNAM, INC.
4 Marina Drive – Suite K-1
Mahopac, NY 10541
Tel: 845-628-2484
Fax: 845-628-2507
email: timeslips@homecareputnam.com

*Period begins on Mondays and ends Sundays

PATIENT/EMPLOYER:	CONSUMER EMPLOYEE PERSONAL ASSISTANT:

DAY	START TIME	END TIME	HOURS WORKED	DATE
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				
SUNDAY				

WEEKLY TOTAL:

I CERTIFY THAT THE ABOVE INFORMATION PROVIDED IS CORRECT AND THAT NO ACTIVITIES CONSIDERED "NOT PERMISSIBLE" BY MEDICAID HAVE BEEN PERFORMED.

CONSUMER EMPLOYEE PERSONAL ASSISTANT:_____

CONSUMER/DESIGNATED REP. EMPLOYER SIGNATURE:_____

TIMESLIPS ARE DUE IN THE OFFICE ON MONDAY

As Fiscal Intermediary to you as Employee/Consumer Aide to the Employer/Consumer, should your duties as a home care worker change and become, or are expected to become, other than the duties stated in the Companionship Services Confirmation: You MUST Immediately inform our office at 845.628.2484 or timeslips@homecareputnam.com , as those changes may not effect only You; but You, the Consumer and the Fiscal Intermediary, and so must be known to us to properly work with. Thank you.