

Month/year \_\_\_\_\_

Client Name \_\_\_\_\_

Provider Name \_\_\_\_\_

# WHEELS ON THE BUS, INC TIMESHEET

Responsible Person Name \_\_\_\_\_

Responsible Person Signature \_\_\_\_\_

Provider Signature \_\_\_\_\_

**\*My signature attests that the service dates and times, as well as Place of Service codes are accurate:**

## Attendant Care

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Date	In	Out	Total	*Ratio	POS	Date	In	Out	Total	*Ratio	POS	
	<b>Total Hours</b>						<b>Total Hours</b>					

**\*In no event will more than three consumers receive the same service with a single direct service staff person at the same time. Ratios are to be written as 1:1 (1 staff to 1 consumer), 1:2 (1 staff to 2 consumers) or 1:3 (1 staff to 3 consumers)**

Please fax or email by **9AM** on the 1<sup>st</sup> and 16<sup>th</sup> of each month to 602 633 1076 or [colettemarotto@yahoo.com](mailto:colettemarotto@yahoo.com).

POS = Place of Service. **Indicate ‘H’ for home to verify that is where service was conducted. These services can *only* take place in the client home.** Payments will not be issued for services provided in unapproved sites, and disciplinary actions will be taken.