The CalPERS Long-Term Care Program

Independent Provider Weekly Time Sheet

Claimant's Name: ____________________

Coverage ID: 41-____________________

Provider Name: ____________________

Provider Phone: ____________________

Mail or fax this form to:
Calpers Long-Term Care Program
P.O. Box 64902
St. Paul, MN 55164-0902
Phone: (800) 982-1775
Fax: (866) 294-6967

INSTRUCTIONS: Please submit a separate weekly time sheet for **each** Independent Provider. A column must be completed for each day of provided services. Enter a check mark for each activity when either **hands on or standby** assistance is provided. Please refer to the instructions for further information.

Date:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time In:							
Time Out:							
Activities of Daily Living:							
Bathing							
Dressing							
Toileting							
Transferring							
Incontinence care							
Eating							
Other Personal Cares:							
Medication Administration							
Ambulation Assistance, Including Walking							
Homemaker Services:							
Meal Preparation							
Laundry							
Housekeeping							
Transportation							
For memory impairment only: *Applicable **only** when the claimant has a severe cognitive impairment*							
Supervision to ensure safety							
Hours Worked:							
Dollars Paid:							

General Comments/Observations/Changes in condition or services (please add additional pages as needed):

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Please note: ***For your protection, some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial penalties may be imposed.*** *If we determine that benefits have been paid under this coverage as a result of your fraudulent action(s), we have the right to recover those benefit amounts. We may recover those benefit amounts directly from you or by reducing any subsequent benefit payments under this coverage. We will determine that manner in which we seek recovery of benefit payments made under fraudulent conditions.* ***In New York, the penalty shall be a fine not to exceed $5,000 and the stated value of the claim for each such violation.***

Total hours worked this period: _________ **Eligible hourly rate:** ____________ **Total charge:** _____________

I declare that all of the above information is complete and true to the best of my knowledge. I understand that the Calpers Long-Term Care Program reserves the right to require additional documentation in support of this claim.

Claimant / Representative Signature: ____ Date: __________

Independent Provider Signature: ____ Date: __________

The time sheet is not to be signed until the work week has been completed and all weekly services have been recorded.

Mail or fax completed Notice of Appeal form and attachments to:

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