outreach HEALTH

North Carolina CAP/Choice Bi-Weekly Time Sheet

Time Sheets are due the Monday after the pay period worked.
Please fax to 866-463-7589 or email to: outreach.nc@outreachhealth.com

COVID 19 FAMILY CAREGIVER

Participant Name _____ Last 4 of Employee SS# _____ Employee Name _____

Week 1	Sun	Mon	Tues	Wed	Thur	Fri	Sat	
Date mm/dd/yy								
Code								
Time In	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	
Time Out	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	
Time In	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	**Weekly Total**
Time Out	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	
Daily Total								0.00

Week 2	Sun	Mon	Tues	Wed	Thur	Fri	Sat	
Date mm/dd/yy								
Code								
Time In	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	
Time Out	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	
Time In	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	**Weekly Total**
Time Out	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	○ AM ○ PM	
Daily Total								0.00

Code Legend:	S5135 - Personal Care Services	S5150 - Personal Aide Respite

Check here if your employee lives with you and is exempt from overtime pay. ☐

The participant was hospitalized this pay period on the following days: _____

Employee/Employer: I certify that the work hours listed above are accurate, that the services provided are in accordance with the current tasks authorized and that services were NOT provided while the Participant was in a hospital, nursing home, or other Medicaid-reimbursed healthcare facility. I understand that falsification of this time sheet is considered Medicaid Fraud,and may result in dismissal from the program and criminal prosecution. / Certifico que las horas de trabajo mencionadas anteriormente son precisas, y que los servicios provenidos son de acuerdo con las tareas autorizadas. Certifico que los servicios no fueron provenidos mientras que el participante estaba en un hospital, asilo de ancianos, o otro centro de atencion medica reembolsado por Medicaid. Entiendo que la falsificacion de esta hoja de tiempo se considerará fraude de Medicaid y puede resultar en la expulsion del programa y enjuicamento penal.

Employer/PR Signature Firma Empleado/Date _____ Employee Signature Firma Empleado/Date _____