STAVROS FISCAL INTERMEDIARY SERVICES

CONSUMER DIRECTED CARE PROGRAM

EMPLOYER NUMBER

P.O. BOX 2130, AMHERST, MA 01004
TEL: 1-800-442-1185 OR (413) 256-6692 X104
FAX: (413) 549-2073

MONTH _____ **YEAR** _____

Employer Name:	**Homemaker Name:**
Address: Street/Number	Address: Street/Number
City: State: Zip Code:	City: State: Zip Code:
Home Phone #	Work Phone #	Home Phone # ( )	Work Phone # ( )
	Social Security Number:
☐ **Employer check if new address and/or telephone**	☐ **Homemaker check if new address and/or telephone**

	Total Day Activity Hours							**Total Day Hrs**
	DAY			**DAY**				
	IN	OUT	IN	OUT	IN	OUT		
1st								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
						Total Hrs.		

	Total Day Activity Hours							**Total Day Hrs**
	DAY			**DAY**				
	IN	OUT	IN	OUT	IN	OUT		
9th								
10th								
11th								
12th								
13th								
14th								
15th								
						Total Hrs.		

BY SIGNING BELOW, I CERTIFY UNDER PAIN AND PENALTY OF PERJURY THAT I HAVE RECEIVED HOMEMAKER SERVICES FROM THE HOMEMAKER DURING THE TIMES DESCRIBED ON THIS ACTIVITY FORM.

EMPLOYER/SURROGATE'S SIGNATURE **DATE**

BY SIGNING BELOW, I CERTIFY UNDER PAIN AND PENALTY OF PERJURY THAT I HAVE PROVIDED HOMEMAKER SERVICES TO THE EMPLOYER DURING THE TIMES DESCRIBED ON THIS ACTIVITY FORM.

HOMEMAKER'S SIGNATURE **DATE**

Please, mail, fax or deliver this signed timesheet within 2 days following the end of recording period to ensure timely payment. Incomplete or illegible timesheets, or timesheets not signed by both the employer/surrogate and the homemaker *will be returned.*