CONTINUUM
FISCAL SERVICES

PARTICIPANT-DIRECTION SERVICES TIMESHEET
PERSONAL ASSISTANCE RETAINER (PAR)

EMPLOYEE NAME:	**EMPLOYER NAME:**
WAIVER PARTICIPANT NAME:	
PARTICIPANT E-MAIL:	

CHECK THE SENTENCE THAT APPLIES

☐ I CERTIFY THAT THE ABOVE NAMED PARTICIPANT WAS HOSPITALIZED IN THE FOLLOWING: (CHECK PLACE OF SERVICE) ☐ SKILLED NURSING FACILITY (31), ☐ NURSING FACILITY (32), ☐ INTERMEDIATE CARE FACILITY/MR (54) OR ☐ INPATIENT HOSPITAL (21). I CERTIFY THAT I WAS SCHEDULED TO PROVIDE CLS SERVICE(S)ON THE DATES AND TIMES INDICATED IN ACCORDANCE WITH THE SERVICE PLAN.

☐ I CERTIFY THAT THE ABOVE NAMED PARTICIPANT WAS OUT OF HOME AND I WAS UNABLE TO WORK AS SCHEDULED TO PROVIDE CLS SERVICES ON THE DATES AND TIMES INDICATED

_____ _____
EMPLOYEE SIGNATURE DATE EMPLOYER SIGNATURE DATE

SERVICE CODES

01 COMMUNITY ACCESS GRP	*02 COMMUNITY ACCESS INDIVIDUAL*	*03 COMMUNITY LIVING 15 MINUTES*
04 COMMUNITY LIVING DAILY	*05 SUPPORTED EMPLOYMENT INDIVIDUAL*	*06 SUPPORTED EMPLOYMENT GROUP*
07 RESPITE 15 MINUTES	*08 RESPITE OVERNIGHT*	*09 COMMUNITY GUIDE*
10 COMMUNITY LIVING RN	*11 COMMUNITY LIVING LPN*	*12 BEHAVIORAL SUPPORTS*

DATE OF SERVICE MM/DD/YY			START TIME ADD AM OR PM	END TIME ADD AM OR PM	TOTAL HOURS	SERVICE CODE

FAX TO: 404-888-9142 or 1-855-872-3728 the day following the last day of the pay period