CONTINUUM
FISCAL SERVICES

EMPLOYEE NAME:	EMPLOYER NAME:
WAIVER PARTICIPANT NAME:	

I CERTIFY THAT I WAS SCHEDULED TO PROVIDE CLS SERVICE(S)ON THE DATES AND TIMES INDICATED IN ACCORDANCE WITH THE SERVICE PLAN.

CHECK THE SENTENCE THAT APPLIES:

_____I CERTIFY THE ABOVE-NAMED PARTICIPANT WAS HOSPITALIZED IN THE FOLLOWING:

☐ **SKILLED NURSING FACILITY (31)**

☐ **INTERMEDIATE CARE FACILITY/MR (54)**

☐ **NURSING FACILITY (32)**

☐ **INPATIENT HOSPITAL (21)**

OR:

_____ 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

03 COMMUNITY LIVING SUPPORTS	*10 COMMUNITY LIVING - RN*	*11 COMMUNITY LIVING - LPN*

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 **EMAIL TO:** timesheet@continuumfs.com

Timesheets DUE the 1st and 16th of each month