Veteran Directed Care Program Timesheet-Illinois

***REQUIRED FIELDS**

Failure to provide the necessary information may result in delays in processing

*EMPLOYEE NAME: _____

*LAST FOUR DIGITS OF SS

*Veteran Name:

 Veteran Name:
 Employer Phone #_____

 Was the Veteran admitted to a hospital or nursing home during any of these dates? Yes_____No_____
 No______

If **YES**, indicate the dates the Veteran was **admitted to and discharged from** the hospital or nursing home

NO SERVICES CAN BE PAID WHILE PARTICIPANT IS ADMITTED TO A HOSPITAL/NURSING HOME

*Please Ente	r Pay Period D	ate F	Range	:				
*Date	*Start Time	1	Р	*End Time	A M	P M	*Service Code	# of Hours Worked
	1							1
	_							-
	_							-
								1
								1
								1
	Total Hours	Wo	rked f	or Current Pa	y Per	iod	1	
*Start &							ements Example: 12:00nm 12:15nm 1	2:15nm etc

Start & End times need to be listed in quarter hour increments. Example: 12:00pm, 12:15pm, 12:45pm, etc.

We (below) certify that the information provided on this form is true, accurate and complete.

*Employee Signature _____

Date

*Employer Signature

Date

Timesheets received by ARIS Solutions after the due dates on the Payroll Schedule will be processed for the next scheduled pay date.

Mail timesheets to: ARIS Solutions- Veteran Dept. PO Box 4409 White River Jct., VT 05001

Phone: 1-866-970-3301 Fax: 1-802-295-9812 Secure Portal: https://arissolutions.org/submit-timesheet/

Please note it is the Veteran/Representative-Employer's responsibility to ensure the accuracy of the service codes used. Be sure to review prior to submission, especially when a Back-up worker is utilized.