ALTSD Program Timesheet- New MexiCare

***REQUIRED FIELDS**

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

***EMPLOYEE NAME:** _____ ***LAST FOUR DIGITS OF SS #:**_____

*** PARTICIPANT NAME:** _____ *** EMPLOYER'S PHONE #:**_____

Was the Participant admitted to a hospital or nursing home during any of these dates? Yes_____No___

If **YES**, indicate the dates the Participant 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 Enter Pay Period Date Range:								
*Date	*Start Time	AM	PM	*End Time	AM	PM	*Service Code (Personal Care/ Transportation)	# of Hours Worked
Total Hours Worked for Current Pay Period								

***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- PO Box 4409 White River Jct., VT 05001

Phone: 1-800-798-1658 **Fax:** 1-802-295-0663

Secure Portal: https://arissolutions.org/fms-payment-submission/

Please note it is the 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.