ALTSD Program Timesheet- New MexiCare

***REQUIRED FIELDS**

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

***EMPLOYEE NAME: PERSON PROVIDING CARE** ***LAST FOUR DIGITS OF SS #: EMPLOYEE SSN**

*** PARTICIPANT NAME: PERSON RECEIVING CARE** *** EMPLOYER'S PHONE #: BEST CONTACT**

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:				**BI-WEEKLY PAY PERIOD PER NM PAYROLL CALENDAR**				
*Date	*Start Time	A M	P M	*End Time	A M	P M	*Service Code (Personal Care/ Transportation)	# of Hours Worked
REQUIRED	REQUIRED	CHOOSE 1		REQUIRED	CHOOSE 1		REQUIRED	
SAMPLE:								
9/30/24	8:00	X		10:00	X		PERSONAL CARE	2
9/30/24	11:45	X		1:00		X	PERSONAL CARE	1:15 OR 1.25
10/1/24	12:00		X	12:45		X	TRANSPORTATION	0:45, 0.75, OR 45 M
10/1/24	2:00		X	2:45		X	TRANSPORTATION	0:45, 0.75, OR 45 M
10/2/24	8:00	X		10:00	X		PERSONAL CARE	2
10/3/24	10:00	X		10:15	X		TRANSPORTATION	0:15, 0.25, OR 15 M
10/3/24	11:00	X		11:15	X		TRANSPORTATION	0:15, 0.25, OR 15 M
10/4/24	1:00		X	3:00		X	PERSONAL CARE	2
10/7/24	8:00	X		10:00	X		PERSONAL CARE	2
10/7/24	11:45	X		1:00		X	PERSONAL CARE	1:15 OR 1.25
10/8/24	12:00		X	12:45		X	TRANSPORTATION	0:45, 0.75, OR 45 M
10/8/24	2:00		X	2:45		X	TRANSPORTATION	0:45, 0.75, OR 45 M
10/9/24	8:00	X		10:00	X		PERSONAL CARE	2
10/10/24	10:00	X		10:15	X		TRANSPORTATION	0:15, 0.25, OR 15 M
10/10/24	11:00	X		11:15	X		TRANSPORTATION	0:15, 0.25, OR 15 M
10/11/24	1:00		X	3:00		X	PERSONAL CARE	2
Total Hours Worked for Current Pay Period								18.5 HOURS

***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 **REQUIRED CONFIRMATION THAT EMPLOYEE AGREES ON SUBMITTED TIME** Date _____

*Employer Signature **REQUIRED EMPLOYER ACKNOWLEDGEMENT** 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.'