STIC CDPA Program Personal Assistant Time sheet Timesheets are due by 7am Monday

STIC, 135 East Frederick Street, Binghamton, NY 13904
Check Box to have an additional supply of time sheets mailed or call 607-724-1111

Per page Per page Per Page Per Page Personal Assistants Signature Per page Per Page Personal Assistant Signature Per page Per Page Per Page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per Page Personal Assistant Signature Date Total Hours Personal Assistant Signature Date Total Hours Personal Assistant Signature Date Total Hours				1 1		<u> </u>	<u> </u>
rsonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have procedure for completing this time sheet and that no hours are being claimed where the country of this time sheet and that no hours are being claimed where the country is always and that I have reviewed this time sheet and it accurately records the personal care services I received on the dates indicated above. I attest that I have reviewed this time sheet and it accurately records the personal care services I received on the dates indicated above. I attest that the services I received were provided as directed on my country DSS care plan and hours were worked during any part of a hospitalization or while I was in a nursing or rehab facility. I understand that falsification of sets or failure to follow any of STIC's policies may result in ineligibility of my personal assistant to provide program services, repayn	Personal Assistant Name	e (please print)	Date Worked	Start Time	End Time	Hours	Type*
rsonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have curately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w issumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we destand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shou low) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demenanc. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Tota							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have prosonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we lerstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have prosonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we lerstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we terstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet and the beginning and end of each shift I worked and that no hours are being claimed we sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we erstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility ide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature Date Total Hours Per page Per page Sonal Assistant Signature Date Total Hours Per page Sonal Assistant							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we terstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we terstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we terstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we terstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
sonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have prosonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we lerstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shouw) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature							
rsonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have prosonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w issumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we learstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shou wi) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or fram for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demenanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Sonal Assistant Signature Date Total Hours Per page Total Hours Per page Sonal Assistant Signature Date Total Hours Per page Sonal Assistant Signature Date Total Hours Per page Total Hours Per page Sonal Assistant Signature Date Total Hours Per page Sonal Assistant Signature D							
rsonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have curately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w issumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we destand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shou low) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or frau for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demenanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility vide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Total Hours Per page Total Hours Personal Assistant Signature Date Total Fer page Total Hours Per page Personal Assistant Signature Date Total Fer Page Total Hours Per page Total Hours Personal Assistant Signature Date Total Fer Page Total Hours Per page Total Hours Personal Assistant Signature Date Total Fer Page Total Hours Per page Total Hours Per page Personal Assistant Signature Date Total Fer Page Total Hours Per page Total Hours Personal Assistant Signature Date Total Fer Page Total Hours Per page Total Hours Personal Assistant Signature Date Total Fer Page Total Fer Page Total Hours Personal Assistant Signature Date Total Fer Page Total Fer Page Total Hours Per Page Total Hours Personal Assistant Signature Date Total Fer							
rsonal Assistant Attests: by my signature, I certify that I have followed the procedure for completing this time sheet and I have presonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have curately recorded my time on this timesheet and the beginning and end of each shift I worked and that no hours are being claimed w insumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we derstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or should be shown) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or frau find furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A sedemeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility wide program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Tesonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Total Hours Per page Total Hours Per page Personal Assistant Signature Date Total Hours Per page Total Hours Per							
sonal care services as directed on my work agreement based on the care plan developed by the county DSS. I attest that I have urately recorded my time on this timesheet ant the beginning and end of each shift I worked and that no hours are being claimed w sumer was hospitalized or in a nursing or rehab facility. I attest that I have signed each page of this timesheet at the end of the we lerstand that this is a Medicaid funded program and that these hours will be billed to Medicaid. I understand that the Federal False (31 USC 3729-3733) imposes liability of any person who submits a claim to the federal government that he or she knows (or shou w) is false. Social Services law 366-b provides that any person who, with the intent to defraud, presents for payment a false or frat m for furnishing services, knowingly submits false information to obtain greater Medicaid compensation is guilty of a Class A demeanor. I understand that recording time that I did not work, or failure to follow any of STIC's policies may result in my ineligibility program services, repayment to STIC for fraudulently billed hours, and / or criminal prosecution. Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Per page Sonal Assistants Signature Date Total Hours Per page Per page Per page Sonal Assistant Signature Date Total Hours Per page Sonal Assistant Sig	Type Code. V Vacation	O Olok	TT TIONGA	ly 5 July Duty	TTTTTOAting	grioliday	
Sonal Assistants Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Per Patronal Assistant Signature Date Total Hours Per page Personal Assistant Signature Date Total Hours Per page Per Patronal Assistant Signature Date Total Hours Per page Per Patronal Assistant Signature Date Total Hours Per page Per Patronal Assistant Signature Date Total Hours Per page Per Patronal Assistant Signature Date Total Hours Per Patronal	sumer was hospitalized or in lerstand that this is a Medicaid (31 USC 3729-3733) impose	his timesheet ant t a nursing or rehab d funded program a s liability of any pe	he beginning and e facility. I attest that and that these hour rson who submits a	end of each shift I work t I have signed each p rs will be billed to Med a claim to the federal g	ed and that no I age of this times caid. I understa overnment that	nours are being sheet at the e nd that the Fe he or she kno	ng claimed whi nd of the wee. ederal False C ows (or should
Per page Total Hours Personal Assistant Signature Date Total Hours Per page Total Hours Personal Assistant Signature Date Total Hours Per page Total Hours Personal Assistant Signature Date Total Hours Per page Total Hours Per page Total Hours Personal Assistant Signature Date Total Hours Per page Total Hours Per page Total Hours Per page Total Hours Personal Assistant Signature Date Total Hours Per page Total Hours Per page Total Hours Personal Assistant Signature Date Total Hours Per page Total Hours Personal Assistant Signature Total Hours Per page Total Hours Personal Assistant Signature Total Hours Per page Total Hours Personal Assistant Signature Total Hours Personal Assistant Sig	nsumer was hospitalized or in derstand that this is a Medicaid (31 USC 3729-3733) impose ow) is false. Social Services la im for furnishing services, kno sdemeanor. I understand that	his timesheet ant t a nursing or rehab d funded program a s liability of any pe w 366-b provides t wingly submits fals recording time that	he beginning and e facility. I attest that and that these hour rson who submits a hat any person who se information to ob I did not work, or f	end of each shift I work t I have signed each p rs will be billed to Med a claim to the federal g o, with the intent to de otain greater Medicaid ailure to follow any of	ed and that no lage of this times caid. I understate overnment that fraud, presents to compensation is STIC's policies r	nours are being sheet at the end that the Foundation or she known for payment as guilty of a C	ng claimed whi nd of the wee. ederal False Cl ows (or should a false or frauda lass A
Per page Total Hours Personal Assistant Signature Date Total Hours Per page Date Total Hours Per page Insumer Attests: by my signature, I swear that I have reviewed this time sheet and it accurately records the personal care services I received on the dates indicated above. I attest that the services I received were provided as directed on my county DSS care plan and hours were worked during any part of a hospitalization or while I was in a nursing or rehab facility. I understand that falsification of seets or failure to follow any of STIC's policies may result in ineligibility of my personal assistant to provide program services, repayn	nsumer was hospitalized or in derstand that this is a Medicaid (31 USC 3729-3733) impose ow) is false. Social Services la im for furnishing services, kno sdemeanor. I understand that ovide program services, repayr	his timesheet ant to a nursing or rehabed funded program as liability of any pew 366-b provides to wingly submits fals recording time that ment to STIC for fragrams.	he beginning and e facility. I attest that and that these hour rson who submits a hat any person who se information to ob I did not work, or f audulently billed ho	end of each shift I work t I have signed each p rs will be billed to Media claim to the federal go, with the intent to de stain greater Medicaid failure to follow any of burs, and / or criminal p	ted and that no lage of this times icaid. I understate overnment that fraud, presents frompensation is STIC's policies rorosecution.	nours are being sheet at the end that the Fender or she know for payment as guilty of a Comay result in	ng claimed whi nd of the wee. ederal False Cl ows (or should a false or fraudd lass A
Per page Per Page nsumer Attests: by my signature, I swear that I have reviewed this time sheet and it accurately records the personal care services I received on the dates indicated above. I attest that the services I received were provided as directed on my county DSS care plan and hours were worked during any part of a hospitalization or while I was in a nursing or rehab facility. I understand that falsification of seets or failure to follow any of STIC's policies may result in ineligibility of my personal assistant to provide program services, repayn	nsumer was hospitalized or in derstand that this is a Medicaid (31 USC 3729-3733) impose ow) is false. Social Services laim for furnishing services, know demeanor. I understand that ovide program services, repayrersonal Assistants Signature	his timesheet ant t a nursing or rehab d funded program a s liability of any pe w 366-b provides t wingly submits fals recording time that ment to STIC for fra	he beginning and e facility. I attest that and that these hour rson who submits a hat any person who se information to ob I did not work, or f audulently billed ho Total Hours Per page	end of each shift I work t I have signed each p rs will be billed to Med a claim to the federal g o, with the intent to de btain greater Medicaid ailure to follow any of burs, and / or criminal p	ted and that no lage of this times icaid. I understate overnment that fraud, presents it compensation is STIC's policies reprosecution.	nours are being sheet at the end that the Found that the Found that the Found that the or she know for payment as guilty of a Comay result in Date	ng claimed whi nd of the wee. ederal False Cl ows (or should a false or frauda lass A my ineligibility to Total Hou
nsumer Attests: by my signature, I swear that I have reviewed this time sheet and it accurately records the personal care services I received on the dates indicated above. I attest that the services I received were provided as directed on my county DSS care plan and hours were worked during any part of a hospitalization or while I was in a nursing or rehab facility. I understand that falsification of sets or failure to follow any of STIC's policies may result in ineligibility of my personal assistant to provide program services, repayn	nsumer was hospitalized or in derstand that this is a Medicaid (31 USC 3729-3733) impose ow) is false. Social Services laim for furnishing services, know demeanor. I understand that ovide program services, repayrrsonal Assistants Signature	his timesheet ant to a nursing or rehabled funded program as a liability of any pew 366-b provides to wingly submits falso recording time that ment to STIC for franched by the Date	he beginning and e facility. I attest that and that these hour rson who submits a hat any person who be information to ob I did not work, or f audulently billed ho Total Hours Per page	end of each shift I work t I have signed each p rs will be billed to Media claim to the federal g o, with the intent to de ptain greater Medicaid failure to follow any of purs, and / or criminal p Personal Assistant S Personal Assistant S	ted and that no lage of this times icaid. I understa overnment that fraud, presents for compensation is STIC's policies rorosecution. Signature	nours are being sheet at the eight of that the Figure 1 or she know for payment as guilty of a Comay result in Date	ng claimed whi nd of the wee. ederal False Cl ows (or should a false or frauda lass A my ineligibility Total Hot
issionity billos nouts and my tomoval form the program. I may also be subject to diffillal pelsecution.	sumer was hospitalized or in lerstand that this is a Medicaid (31 USC 3729-3733) impose w) is false. Social Services lam for furnishing services, knodemeanor. I understand that vide program services, repayr sonal Assistants Signature sonal Assistants Signature	his timesheet ant to a nursing or rehable of funded program as a liability of any pew 366-b provides to wingly submits falso recording time that ment to STIC for franched by the Date	he beginning and e facility. I attest that and that these hour rson who submits a hat any person who se information to ob I did not work, or f audulently billed ho Total Hours Per page Total Hours Per page Total Hours	end of each shift I work t I have signed each p rs will be billed to Med a claim to the federal g o, with the intent to de btain greater Medicaid ailure to follow any of burs, and / or criminal p Personal Assistant S Personal Assistant S	ted and that no lage of this times icaid. I understa overnment that fraud, presents frompensation is STIC's policies rorosecution. Signature Signature	nours are being sheet at the eight and that the Feinder or she known for payment as guilty of a Comay result in Date	ng claimed whind of the wee. ederal False Cows (or should a false or fraud lass A my ineligibility Total Hoper Page Total Hoper Page Total Hoper Page
	Issumer was hospitalized or in lerstand that this is a Medicaid (31 USC 3729-3733) impose (31 USC 3729-3733) impose (31 USC 3729-3733) impose (32 US	his timesheet ant to a nursing or rehable of funded program as liability of any pew 366-b provides to wingly submits falso recording time that ment to STIC for franched by Date Date Date Date Date Date Date Date Date Date	he beginning and e facility. I attest that and that these hour rson who submits a hat any person who se information to ob. I did not work, or f audulently billed ho Total Hours Per page Total Hours Per page Total Hours Per page ave reviewed this t the services I recei zation or while I wa y result in ineligibili	end of each shift I work at I have signed each p rs will be billed to Media a claim to the federal g o, with the intent to de betain greater Medicaid ailure to follow any of burs, and / or criminal p Personal Assistant s Personal Assistant s Personal Assistant s ime sheet and it accur ved were provided as as in a nursing or rehal ty of my personal assist to Medical Personal Assistant s as in a nursing or rehal ty of my personal assist ty of my personal assist The transfer of the tran	age of this times icaid. I understa overnment that fraud, presents frompensation is STIC's policies rorosecution. Signature Signature Signature ately records the directed on my of facility. I understant to provide	nours are being sheet at the eight and that the Fe he or she know for payment as guilty of a Comay result in Date Date Date Date Date	Total Ho Per Page Total Ho Per Page