32227

ODA PASSPORT Provider Timesheet

Provider's Name: ______________________

PPL Provider ID: P O D A

Participant's Name: ______________________

Participant ID: C O D A

Service Type (fill one)
- ○ Choices - HCAS Travel
- ○ Choices - HCAS
- ○ CD-PCS
- ○ CD-PCS Group

FAX: PPL @ 1-866-346-0609   MAIL: PUBLIC PARTNERSHIPS, LLC - ODA Passport, 17 Plaza Dr., Latham, NY 12110

Year 2 0 __ __   Month __ __   Specify Pay Period: ○ 1st - 15th   ○ 16th to End of Month

Day Worked	Time IN HH	MM		Time OUT HH	MM		Time IN HH	MM		Time OUT HH	MM		Total Hours HH	MM
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
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			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		
			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○			AM ○ PM ○		

TOTAL HOURS WORKED ON THIS TIMESHEET: ___ : ___

By signing below, I certify that I have provided the services to the participant during the times described on this timesheet.

Date: __ __ / __ __ / 2 0 __ __

Provider Signature: ______________________

I certify that the participant has received hours of service as reported above.

Date: __ __ / __ __ / 2 0 __ __

Participant/Employer Signature: ______________________

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