CO CDASS Program Timesheet

FAX: PPL @ 1-866-741-2718

Member: (Last Name, First Name) _____ Member ID: _____

Employee: (Last Name, First Name) _____ Employee ID: _____

PAY PERIOD: ○ 1st ○ 2nd

Month: ____

Year: 2 0 ____ ____

Service Types: **1/Blank** CDASS - Standard; **2** CDASS - Emergency; **3** CDASS - Other; **4** SLS Health Maintenance - Standard; **5** SLS Health Maintenance - Emergency; **6** SLS Health Maintenance - Other

Day of Month	Service Type	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 ○	:

I certify and affirm that this timesheet is an accurate representation of services rendered by the named employee to the named supervisor. Misrepresentation or false statements may result in administrative penalties, criminal prosecution and/or termination from the CDASS program.

Employee Signature: _____ Supervisor/AR Signature: _____

Date: ____ / ____ / 2 0 ____ Date: ____ / ____ / 2 0 ____

USE BLACK INK, PRINT ONE CHARACTER PER BOX, TRY NOT TO TOUCH THE LINES!!!

CORRECT → 1 2 0 1 2 9

INCORRECT → 3 O 2 4 2 9

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