BDS FISCAL

This is a fillable form.

Fiscal Agent Employee Timesheet

Employee/Provider Name *(one per timesheet)* ______________________

Employer/Service Recipient Name *(child's name)* ______________________

Pay Period: ______________ to ______________

Employer/Service Recipient County of Residence ______________________

ATTENTION

- BDS Fiscal will email the worker and the parent/supervisor log-in credentials to be used for all future timesheets, which will be electronic. That email will be sent after the worker's first pay date.
- One pay period per timesheet.
- Round to nearest 15-minute increment for hour totals (15min = .25 30min = .5 45min = .75).
- Must have active authorization from county before we can process payroll.
- Hours that exceed 40 per week (Sun-Sat), or hours that exceed the amount authorized will NOT be paid.

Date	Service	Start	End	# of Hours
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
	○ Hourly ○ Daily	○ AM ○ PM	○ AM ○ PM	
			Totals:	

Service types:

Child Care Hrs - Individual = **CC**	Personal Support = **PS**
Child Care Hrs - Group = **CCG**	Personal Support - Group = **PSG**
Child Care Day = **CCD**	Respite Care Hrs - Individual = **R**
Child Care Day - Group = **CCDG**	Respite Care Hrs - Group = **RG**
Daily Living Skills = **DLS**	Respite Day = **RD**
Mentoring = **M**	Respite Day - Group = **RDG**

I/We certify that the information provided on this form is a true and accurate statement of the services provided, that the services were provided in accordance with the care plan, and that the Client/Service Recipient was not hospitalized during the time services were provided. I/We understand that payment for services provided are subject to payroll taxes and that falsification of this timesheet is considered Medicaid fraud and may result in dismissal from employment and/or criminal prosecution.

Employee/Provider Signature ______________________ **Date** __________

Employer Representative/Parent Signature ______________________ **Date** __________

Print form to add signatures

Timesheets must be submitted to BDS Fiscal within 30 days of service.

Mail: 6102 W Layton Avenue, Greenfield, WI 53220 • Fax: 414-329-4510

Email: bdsfiscal@broadscope.org • Text: 262-373-9870

Refer to current payroll schedule for pay dates. BDS Fiscal is associated with Broadscope Disability Services, Inc.

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