

FLEXIBLE CHOICES EMPLOYEE TIMESHEET

EMPLOYEE NAME: _____ SS# _____ DATE: _____

CONSUMER NAME: _____

Did the consumer have a hospital or nursing home stay during any of these dates? Yes ___ No ___

If YES, please indicate the dates the consumer was admitted to and discharged from the hospital.

DATE	START TIME	END TIME	NO. OF HOURS WORKED	HOURLY PAY

In the event that my total expenses for this bi-weekly period exceeds my approved allocation, I authorize ARIS Solutions to use any available funds from my saving, in order to assure payment of this timesheet.

EMPLOYER SIGNATURE _____ DATE: _____

We, the undersigned, do hereby certify, under the pains and penalty of perjury, to the best of our knowledge, this timesheet accurately represents the hours actually worked by the worker. *No time submitted occurred while the consumer was in a nursing home or hospital.* We understand that submitting an inaccurate timesheet may result in termination of the employer and/or the worker from this program and may result in civil and/or criminal penalties.

EMPLOYEE SIGNATURE _____ DATE _____

EMPLOYER SIGNATURE _____ DATE _____

PRINT EMPLOYER NAME: _____

TIMESHEETS MUST BE SUBMITTED EVERY TWO WEEKS ACCORDING TO THE PAY SCHEDULE. TIMESHEETS MUST BE POSTMARKED BY FRIDAY AND/OR BE RECEIVED IN THE ARIS SOLUTIONS OFFICE NO LATER THAN MONDAY OF THE PAY WEEK TO ENSURE PAYMENT. ARIS SOLUTIONS IS UNABLE TO ACCEPT FAXED OR PHOTOCOPIED TIMESHEETS.

SEND TO: ARIS SOLUTIONS
PO BOX 4409
WHITE RIVER JUNCTION, VT. 05001

QUESTIONS? CALL 1-800-798-1658