Tips for Timesheets

Always fill out timesheets with an INK pen!! Don't forget to sign and date the timesheet!

❶ Section ① contains the recipient's (IHSS consumer's) name and address *and* the provider's (homecare worker's) name and address. Check to make sure your address is correct. If either has moved, check the "yes" box under the changed address and write the new address on the back of the timesheet.

❷ The first row of section ② lists the days of the month for this time period. Write the number of hours the provider worked below each day worked. Write the total number of hours worked at the end of the row.

❸ The recipient and provider must sign and date section ③ *after* the last day worked for this pay period. Remember, the RECIPIENT SIGNATURE is referring to the consumer and the PROVIDER SIGNATURE is referring to the home care worker.

❹ The example timesheet below is for the first pay period of the month. Homecare workers cannot be paid for more then 59% of the total Employer Service Hours for the month in the first pay period. In the second pay period of the month, homecare workers can not be paid for more than the remaining "Employer Service Hours" which are listed on the timesheet.

❺ Mail your time sheet in the envelope provided. Make sure the IHSS address shows clearly through the window. Don't forget a stamp and your return address!

THE TIMESHEET MUST BE COMPLETED WITH THE HOURS YOU WORKED AND RETURNED TO THE COUNTY IHSS ADDRESS LISTED BELOW.
LA HOJA DE HORAS TRABAJADAS TIENE QUE SER COMPLETADA CON LAS HORAS QUE USTED TRABAJO Y DEBE SER REGRESADA
A LA DIRECCION DEL CONDADO PARA IHSS.

MANUAL - PAYROLL ISSUED REPLACEMENT TIMESHEET	IHSS TIMESHEET
Recipient Number 01-	Provider Number 1
x X X	x x x
ADDRESS CHANGE YES( ) WRITE NEW ADDRESS ON REVERSE SIDE	ADDRESS CHANGE YES( ) WRITE NEW ADDRESS ON REVERSE SIDE

① ④

SIGN, DATE AND MAIL TIMESHEET AFTER ALL WORK COMPLETED IN PAY PERIOD

EMPLOYER SERVICE HOURS ARE: 0.0

FOR THE ENTIRE MONTH

②

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	X	TOTAL HRS WORKED
Hours Worked	✓															X	

Fill in hours for each day worked and place total here.
Llene las horas para cada dia que trabajo y apunte el total aqui.

Share of Cost Liability			
$0.00		Other Liability	Provider Overpayment

Do not sign unless you have read and understand instructions above
No firme hasta que haya leido y entendido las instrucciones al dorso

SW NO. M DO. 3	RECIPIENT SIGNATURE 01-
	X DATE
ALAMEDA CO. SOC. SVCS. AGENCY 6955 FOOTHILL BLVD STE 300 OAKLAND, CA 94605-2409	PROVIDER SIGNATURE 1 ③
	X DATE
O.K. TO PROCESS ____	AFTER WORK HAS BEEN COMPLETED, SIGN, DATE AND MAIL TO THIS ADDRESS. UNA VEZ QUE SE HAYA COMPLETADO EL TRABAJO, FIRMESE Y ENVIESE A ESTA DIRECCION.

This is to certify that the information contained in this form is true, accurate and complete, and that the provider and recipient have read, understand and agree to be bound by and comply with the statements, affirmations and conditions contained on the back of this form.
Por medio de la presente certifico que la informacion que contiene esta forma es verdadera, correcta y completa, y que el proveedor y la persona que recibe los beneficios han leido, entienden y estan de acuerdo en someterse a y cumplir con las declaraciones, afirmaciones y condiciones que contiene el dorso de sta forma.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY - DEPARTMENT OF SOCIAL SERVICES

Rev. 1-2012

ENHANCING THE IHSS EXPERIENCE
Public Authority For IHSS
in Alameda County