

Employee Time Sheet (EPAS)

Employee Name: _____

Client Name: _____

Month Ending: _____

Employer Name: _____

1 st through the 15 th						
Date	Service	Start	End	Rate	Hours	Explanation of Service*
1		AM PM	AM PM			
2		AM PM	AM PM			
3		AM PM	AM PM			
4		AM PM	AM PM			
5		AM PM	AM PM			
6		AM PM	AM PM			
7		AM PM	AM PM			
8		AM PM	AM PM			
9		AM PM	AM PM			
10		AM PM	AM PM			
11		AM PM	AM PM			
12		AM PM	AM PM			
13		AM PM	AM PM			
14		AM PM	AM PM			
15		AM PM	AM PM			
<i>This timesheet is due by the 19th of each month.</i>						*Timesheet <u>will not</u> be paid without an explanation of service.

I certify, under penalty of prosecution and repayment of funds, that this is an accurate record of the services I have provided. I also agree to the rate(s) of pay as indicated above.

Employee Signature

I certify, under penalty of removal from the program, prosecution, and repayment of funds, that this is an accurate record of the services this employee has provided. I also agree to pay the employee the rate(s) of pay indicated above. I also certify I am eligible for Medicaid and have current EPAS authorization.

Employer's Signature

FAX: 1-801-359-4698 / 1-877-359-4698 EMAIL: timesheets@leonardconsultingllc.com
Leonard Consulting LLC 370 E. South Temple, Ste. 300, SLC, UT 84111

Employee Time Sheet (EPAS)

Employee Name: _____

Client Name: _____

Month Ending: _____

Employer Name: _____

16 th through the 31 st						
Date	Service	Start	End	Rate	Hours	Explanation of Service*
16		AM PM	AM PM			
17		AM PM	AM PM			
18		AM PM	AM PM			
19		AM PM	AM PM			
20		AM PM	AM PM			
21		AM PM	AM PM			
22		AM PM	AM PM			
23		AM PM	AM PM			
24		AM PM	AM PM			
25		AM PM	AM PM			
26		AM PM	AM PM			
27		AM PM	AM PM			
28		AM PM	AM PM			
29		AM PM	AM PM			
30		AM PM	AM PM			
31		AM PM	AM PM			
<i>This timesheet is due by the 4th of each month.</i>						*Timesheet will not be paid without an explanation of service.

I certify, under penalty of prosecution and repayment of funds, that this is an accurate record of the services I have provided. I also agree to the rate(s) of pay as indicated above.

Employee Signature

I certify, under penalty of removal from the program, prosecution, and repayment of funds, that this is an accurate record of the services this employee has provided. I also agree to pay the employee the rate(s) of pay indicated above. I also certify I am eligible for Medicaid and have current EPAS authorization.

Employer's Signature

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