Rainbow Home Healthcare
Better Health For Independent Living

1358 7th Street East
Saint Paul, MN 55106
Business Phone: (651) 778-0562
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Acknowledgement of Submitted Timesheets

To all Employees and Clients,

The Minnesota Department of Human Services (DHS) and Surveillance Integrity Review Section (SIRS) is required by law to review and monitor your information on billing for Medical Assistance. SIRS has access to timecards you submitted to the agency and are aware of the dates and time that you provide services. As a reminder, you can only submit time records for services and time that you are working for the client according to the authorization.

You cannot submit timesheet if you or the client is in:

- Hospital Stay
- Nursing Home
- Working
- Traveling
- Or Attending School you cannot bill etc.

TIMESHEET IS NOT ACCEPTABLE IF…

- ***White-Out***
- **Pre-sign before due date**
- **No Signatures of both the Client and PCA**
- **No Initials to indicate task has been completed**
- **No Time-in & Time-Out (AM or PM)**

Please use ONLY BLACK INK to fill out your timesheet.

If you are unsure whether you can or cannot submit timesheet, please contact our Rainbow Home Healthcare, Inc. agency at 651-778-0562.

It's a federal crime to provide false information to DHS. If SIRS discover that you have submitted false timecards; you will be suspended or terminated as a provider in MHCP. You may also be subject to criminal sanctions such as capital punishment, incarceration, or severe fines.

As your agency, we request that you notified us when you or the client is in the Hospital, Nursing Home, Working, Attending School or Traveling out of state/country. Failure to do so will result in violations of federal law.

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I have read and understand the above terms and conditions

PCA: I am willing to sign this form. I agree that I am responsible for submitting time cards for service that I provided and may only be paid for the time spent assisting the client as specified on the care plan.

Client/RP: I am willing to sign this form. I agree that I am responsible for reviewing time cards for services provided and the PCA may only be paid for the time spent assisting me (family member) as specified on the care plan.

_____	_____	_____
Employee Print Name	Signature	Date
_____	_____	_____
Client/RP Print Name	Signature	Date