State of Illinois
Department of Human Services - Division of Rehabilitation Services

HOME SERVICES PROGRAM TIME SHEET INSTRUCTIONS

❶ District: ____________

Case Number: ____________ | Worker last four of SSN:

❷ Customer Name: ____________
Address: ____________ Apt. #: ____________
City/Zip Code: ____________
Phone:(______) ____________
☐ Information has changed since last time sheet was submitted.
Email ____________

☐ Information has changed since last time sheet was submitted.
NOTE: Check will be mailed to Individual Provider's home address ❸
Worker Name: ____________
Home Address: ____________ Apt. #: ____________
City/Zip Code: ____________
Phone:(______) ____________
Email ____________

❹ **Month:** ____________ **Year:** ____________

	Dates: (check box)		Indicate AM or PM with each start and stop time						
☐ **Personal Assistant** ❺	☐	☐	Start	Stop	Start	Stop	Start	Stop	Daily Total
Rate:	1st	16th							
☐ **Certified Nurse Assistant**	2nd	17th							
	3rd	18th		❻					
Rate:	4th	19th							
☐ **Licensed Practical Nurse**	5th	20th							
	6th	21st							
Rate:	7th	22nd							
☐ **Registered Nurse**	8th	23rd							
	9th	24th							
Rate:	10th	25th							
☐ **Physical or Occupational Therapist**	11th	26th							
	12th	27th							
Rate:	13th	28th							
☐ **Speech Therapist**	14th	29th							
	15th	30th							
Rate:		31st							
								Pay Period Total	

INFORMATION ONLY

CUSTOMER/INDIVIDUAL PROVIDER CERTIFICATION FOR SERVICES RENDERED

I certify that the above information is true and in accordance with the Individual Provider Payment Policies (IL488-2252). I certify the above information is true and that the customer was in his or her home at the time services were rendered (not on unapproved vacation, in the hospital, in a nursing home, etc.). I understand falsification of any information submitted on this form could lead to criminal prosecution. I certify that the above information is true and in accordance with the Individual Provider Payment Policies (IL488-2252). I certify the above information is true.

❼ Worker Signature: ____________ Date: ____________

I certify that the above information is true and that services were received as stated. I understand falsification of any information submitted on this form could lead to criminal prosecution.

❽ Customer Signature: ____________ Date: ____________

---------- **FOR OFFICE USE ONLY** ----------

DHS Payment Approval: ____________ Date: ____________ Gross: ____________ Auth.: ____________

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HOME SERVICES PROGRAM TIME SHEET INSTRUCTIONS

All fields required to be completed in order for timesheet to be processed.

1. Enter the three digit district number.
2. Enter Case Number, Customer Name, Address, Zip Code, current Phone Number and email address. Mark the box if this information has changed.
3. Enter Worker last four of SSN, Worker Name, Address, Zip Code, current Phone Number, and email address. Mark the box if the information has changed.
4. Enter the month and the year that the service was provided.
5. If you are working as something other than a P.A., please check the box.
6. List the exact time provided to you via the EVV system. Do NOT Round.
7. Worker Signature and Date.
8. Customer Signature and Date.

PROVIDER HOTLINE

Call this number FIRST for information about your checks.

1-800-804-3833