CTD Coalition of Texans with Disabilities
Consumer Directed Services Division

(*Print*) **EMPLOYER NAME:** _____ Date: _____

Address: _____ PH#: _____

Email **:** _____

(*Print*) **EMPLOYEE NAME:** _____

Address: _____ PH#: _____

Email **:** _____

SERVICE PROVIDED: CIRCLE ONE	PAS	RESPITE	PROTECTIVE SUPERVISION

TIME SHEETS ARE DUE ON/BEFORE 11:59PM EVERY **SATURDAY**.
LATE TIMESHEETS WILL BE PROCESSED ON THE NEXT PAY PERIOD

FAX TIMESHEETS TO 512 236 1040
EMAIL TIMESHEETS TO TIMESHEETS@TXDISABILITIES.ORG

DAY OF WEEK	DATE	Time in	Time out	Time in	Time out	Total Time	Comments
SUNDAY							
MONDAY							
TUESDAY							
WEDNESDAY							
THURSDAY							
FRIDAY							
SATURDAY							

Total Hours:

I am aware of my authorized weekly hours per my HMO and I will stay within the approved number of hours.

By the employer and employee signing this document, both parties agree that these hours have been worked and the assigned tasks have been performed. BOTH EMPLOYER AND EMPLOYEE MUST SIGN THIS DOCUMENT.

Employer: _____ Date: _____

Employee: _____ Date: _____

REMEMBER>>>FRAUD>>> IT'S AGAINS THE LAW. YOU COULD LOOSE YOUR BENEFITS AND MORE.
EMPLOYER; ARE YOU AUTHORIZING A BONUS ON THIS PAYCHECK? NO YES $