

TIME CARD
 Alta California Regional Center
 Day Care(405)
 In-Home Respite Worker(864)

PARENT / GUARDIAN: _____ VENDOR#: _____

CARE SITE ADDRESS: _____

CONSUMER UCI#: _____ CONSUMER NAME: _____

EMPLOYEE NAME: _____ RELATIVE? SPECIFY: _____

EMPLOYEE **STREET** ADDRESS: _____
(PO BOX NOT ACCEPTABLE)

EMPLOYEE BIRTHDATE: _____ EMPLOYEE PHONE #: _____

DATE	START TIME	END TIME	# OF HOURS	WAGE	TOTAL WAGE

Specify AM or PM on Start and End Times

TOTALS

I certify that I provided only non-medical services to the consumer and in the location indicated above, and that all information is correct.

 EMPLOYEE SIGNATURE DATE SOCIAL SECURITY NUMBER

I certify that the employee signing above was employed, trained, and assigned all duties solely by me. I further certify that the hours and wages shown above are correct and that the employee performed satisfactorily, meeting all requirements of Title 17. I certify that I am aware of all the requirements of this program as outlined in the vendor application and I am in full compliance. These claims are submitted under penalty of perjury in accordance with the terms and conditions on the reverse side of this form.

 PARENT / GUARDIAN SIGNATURE DATE

***For prompt reimbursement, the TAI and Time Card must be received by the Accounting Department by the 5th following the service month.*
 NO PAYMENT WILL BE MADE UNLESS THIS FORM IS COMPLETELY FILLED OUT, INCLUDING ORIGINAL SIGNATURES.

CERTIFICATION STATEMENT

1. The Provider agrees and shall certify under penalty of perjury that all claims for service provided to regional center clients have been provided to the clients by the Provider.
2. The services were, to the best of my knowledge, provided in accordance with the client's written Individual Program Plan.
3. The Provider certifies that all information submitted to the regional center is accurate and complete.
4. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state law.
5. The Provider agrees to keep for a minimum period of **five** years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client.
6. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to : the California Department of Health Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives.
7. The Provider agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.