

TIME CARD - Payroll Model Employee

CCP Self Directed Services

1885 University Avenue West ~ Suite 398 ~ St. Paul, MN 55104
 (T) 651-209-3350 (Toll Free) 1-877-917-2404
 (Fax) 651-641-8623 (Toll Free Fax) 1-877-730-9701
 Email: sabdouch@theccpinc.com; ldudrow@theccpinc.com; alawrence@theccpinc.com

Employee (Full name) _____

Consumer Name: _____

**** Time cards are due every other Wednesday at noon. Time cards received after the cutoff will be processed with the next payroll period.**

**Enter the month, date and year of each shift.

**Indicate start and end times (a.m./p.m.) for each shift, including respite.

**Time cards must be signed by the managing party and employee.

**If working respite hours, please indicate this next to the day the shift occurred.

**Please do not hold time cards. They must be submitted each payroll cycle if hours have been worked.

Date	Day of Week	Starting Time (a.m./p.m.)	Ending Time (a.m./p.m.)	Total Hours
/ /	Sunday			
/ /	Monday			
/ /	Tuesday			
/ /	Wednesday			
/ /	Thursday			
/ /	Friday			
/ /	Saturday			
Total Hours for Week 1				

Date	Day of Week	Starting Time (a.m./p.m.)	Ending Time (a.m./p.m.)	Total Hours
/ /	Sunday			
/ /	Monday			
/ /	Tuesday			
/ /	Wednesday			
/ /	Thursday			
/ /	Friday			
/ /	Saturday			
Total Hours for Week 2				

Hourly Wage: \$ _____ Total Regular Hours Worked: _____ Total: \$ _____

Overtime Wage: \$ _____ Total Overtime Hours Worked: _____ Total: \$ _____

Respite Wage: \$ _____ Total Respite Hours Worked: _____ Total: \$ _____

Total \$\$ Earned This Pay Period: \$ _____

Employee signature: _____ Date: _____

Managing Party Signature: _____ Date: _____

** By signing this time card you are verifying the above are actual hours worked.

** REMINDER - Hours can not be submitted while waiver recipient is admitted to hospital, nursing or residential facility