



TIME CARD

CCP Self Directed Services

1295 Bandana Blvd N ~ Suite 135 ~ St. Paul, MN 55108
 (T) 651-209-3350 (F) 651-641-8623
 (Toll Free) 1-877-917-2404 (Toll Free Fax) 1-877-730-9701

Employee Name: _____ Employee Number: _____

Individual Receiving Services: _____

**** Time cards are due every other Wednesday by 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.**

****Employee is responsible to notify CCP immediately upon reduction of hours, change in schedule or status for new assignment.**

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 Reg Hours Worked: _____ Total: \$ _____

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

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

Total Amount 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 facility, long-term care facility or residential facility.**