

# MFP Self-directed Waiver Services

Payroll Period From Sunday / / Through Saturday / /

Employer Name \_\_\_\_\_ Employer Number 

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Employer check only if new address, telephone, or e-mail and attach change form.

## FI Contact Information

DCW Name \_\_\_\_\_

DCW Social Security Number (Last 4 digits only) 

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DCW check only if new address, telephone, or e-mail and attach change form.

**Codes:** 1 - Adult Companion    2 - Chore Service    3 - Homemaker    4 - Individual Support and Community Habilitation    5 - Personal Care    6 - Peer Support

Week 1	Code #	Time In	Time Out	Total
Sun.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Mon.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Tue.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Wed.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Thu.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Fri.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Sat.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Total Hours for Week 1				: : : : : :

By signing below, I certify under pain and penalty of perjury that I have received MassHealth self-directed services from the DCW during the times described on this activity form.

**X** \_\_\_\_\_  
Employer/Surrogate's Signature \_\_\_\_\_ Date \_\_\_\_\_

Week 2	Code #	Time In	Time Out	Total
Sun.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Mon.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Tue.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Wed.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Thu.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Fri.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Sat.		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
		: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM	: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Total Hours for Week 2				: : : : : :

By signing below, I certify under pain and penalty of perjury that I have provided MassHealth self-directed services to the waiver participant during the times described on this activity form.

**X** \_\_\_\_\_  
DCW's Signature \_\_\_\_\_ Date \_\_\_\_\_