MFP/ABI Self-Directed Waiver Services

TEMPUS UNLIMITED, INC., 600 Technology Center Drive, Stoughton, MA 02072
Toll-free Phone #: 1-877-479-7577 Toll-free Fax #: 1-800-359-2884

Payroll Period From: ☐☐ / ☐☐ / ☐☐ To: ☐☐ / ☐☐ / ☐☐

Employer #: ☐☐☐☐☐☐ Telephone #: _____

Employer Name (Print): _____

DCW Name (Print): _____

DCW Telephone #: _____

DCW Last 4 Digits of SSN ☐☐☐☐

* USE FOR PAID TIME OFF ONLY *

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Please record the hours your DCW was scheduled to work but instead is requesting Paid Time Off. Use Codes 1-6 to note the service that the DCW was scheduled to provide. If the DCW was unscheduled, use Code 0.

Codes: 1 - Adult Companion 2 - Chore Service 3 - Homemaker 4 - Individual Support and Community Habilitation 5 - Personal Care 6 - Peer Support 0 - Unscheduled

WEEK #1	Code	Scheduled Time In HRS MIN	Scheduled Time Out HRS MIN	Total Scheduled Hours HRS MIN
Sun.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Mon.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Tue.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Wed.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Thu.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Fri.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Sat.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:

Total Week 1 Please note that Tempus pays the DCW based on daily, not weekly, totals. ☐☐☐ : ☐☐

WEEK #2	Code	Scheduled Time In HRS MIN	Scheduled Time Out HRS MIN	Total Scheduled Hours HRS MIN
Sun.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Mon.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Tue.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Wed.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Thu.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Fri.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:
Sat.		: O AM O PM	: O AM O PM	:
		: O AM O PM	: O AM O PM	:

Total Week 2 Please note that Tempus pays the DCW based on daily, not weekly, totals. ☐☐☐ : ☐☐

By signing below, I certify under pain and penalty of perjury that I was scheduled to receive MassHealth HCBS ABI/MFP Self-Directed services from the DCW during the Paid Time Off taken as indicated on this activity form with Codes 1 - 6. I certify under pain and penalty of perjury that I was not scheduled to receive MassHealth HCBS ABI/MFP Self-Directed services from the DCW during the Paid Time Off taken as indicated on this activity form with Code 0.

By signing below, I certify under pain and penalty of perjury that I was scheduled to provide MassHealth HCBS ABI/MFP Self-Directed services to the waiver participant during the Paid Time Off taken, as indicated on this activity form with Codes 1 - 6. I understand I must have accrued Paid Time Off in order to receive Paid Time Off. I certify under pain and penalty of perjury that I was not scheduled to provide MassHealth HCBS ABI/MFP Self-Directed services to the waiver participant during the Paid Time Off taken, as indicated on this activity form with Code 0.

Employer/Surrogate's Signature & Date

DCW's Signature & Date