

Pennsylvania Participant Directed Services Program



Employee ID input boxes

EMPLOYEE ID

Participant ID input boxes

PARTICIPANT ID

EMPLOYEE NAME (LAST NAME, FIRST NAME)

PARTICIPANT NAME (LAST NAME, FIRST NAME)

I attest that these services were delivered and received consistent with the Individual Support Plan and that I am in compliance with all waiver requirements. I understand that Medicaid is the payer of last resort.

Employee Signature

Date

Employer Signature

Date

Table with 4 columns: SERVICE DATE (Month, Day, Year), CHECK IN TIME, CHECK OUT TIME, SERVICE. Each row contains input boxes for date, time (AM/PM), and service type.

Please fax WITHOUT COVERSHEET toll free to 1-866-571-3682 or mail to Acumen, 4542 East Inverness Ave. Suite 210, Mesa, Az. 85206.