Services Delivered Report Form – Page 1 of 2

Deschutes County

Client Name:	**Prime#:**
Service Authorized:	**Max:**
Service Coordinator Name:	

Provider (PSW) Name:	**Provider#:**

Services Delivered On: Month: _____ Year: _____

Date	**Start Time**	**End Time**	**Total Hours**	**# of Clients**
	(Round to nearest quarter hour, circle AM/PM)			
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
	AM PM	AM PM		
		Total Hours:		

Reporting dates/times worked in excess of the amount of service authorized or not consistent with the recipient's service plan may be considered Medicaid Fraud.

Services Delivered Report Form – Page 2 of 2

Deschutes County

Client Name:	**Prime#:**

Provider (PSW) Name:	**Provider#:**

Service Goal:

Progress Notes (attach additional pages as needed):

RECIPIENT/EMPLOYER/EMPLOYEE VERIFICATION

I affirm that the data reported on this form is for actual dates/time worked by the delivering the service/supports listed to the recipient, that it does not exceed the total amount of service authorized, and was delivered according to the recipient's service plan and provider/recipient service agreement. I further acknowledge that **reporting dates/time worked in excess of the amount of service authorized or not consistent with the recipient's service plan may be considered Medicaid Fraud.**

_____

Employer/Rep Signature **Date**

_____

Employee/Provider Signature **Date**

_____ (**Employee/Provider Initials**) I authorize CDDP/Brokerage staff to enter the data reported on this from into eXPRS on my behalf for claims creation and payment.

CDDP REVIEW: This service delivery report has been reviewed and is consistent with the recipient's service plan and authorized service limits.

_____

CDDP Rep Signature Date

EMPLOYER: retain copy for your records. Fax or hand-deliver timesheets to:

Deschutes County Developmental Disabilities / Attn. Geneva Blunt
1340 NW Wall St. Bend, OR 97701
FAX: 541-330-4636
Phone: 541-322-7554