Medina County
board of developmental disabilities

Family Support Services
Respite Provider Time Sheet

Month _____ Year _____ Provider Name (please print) _____

Enrollee's Name _____

Date	Time In	Time Out	Total Hours	Rate*	Family Co-Pay	MCBDD Pay	Initials of Verify Family Member
TOTALS							

***Rate negotiated with family up to waiver reimbursement rates (5123:2-9-30, Appendix A, Category 6)**

Allotment Balance _____

I certify that the above hours submitted are true and correct.

Provider Signature _____ Social Security Number _____

Address _____ Telephone Number _____

Date _____

Please take a moment to answers these survey questions. Any information that you are able to share will help us with future planning.

Do you use the agency website (www.mcbdd.org) for information about the FSS Program or to download forms? ☐ yes ☐ no

What suggestions do you have to improve the FSS program? _____

_____

Submit to: MCBDD Attn. Medicaid Services Manager, 4691 Windfall Road, Medina, OH 44256

Scan/Email to: FSSinfo@mcbdd.org

Fax: 330-722-4854

MCBDD - SSA
Revised: 6/12, 10/13, 6/18
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