Medina County
board of developmental disabilities

# Supported Living
## Provider Time Sheet

| Date | Enrollee's Name | Time In | Time Out | Total Hours | Rate / Hour | Total Reimbursement | Guardian Initials |
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| **TOTALS** | | | | | | | |

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

Provider Printed Name_____

Provider Signature_____ Date_____ Social Security Number _____

Address_____ Telephone Number _____

Mail to: Medina County Board of DD, Attn: Medicaid Services Manager, 4691 Windfall Road, Medina, Ohio 44256

Scan/Email to: SLinfo@mcbdd.org Fax: 330-722-4854

(Extra forms available at www.mcbdd.org)

MCBDD
0303092
RC-2: R-60
REV: 10/18