Supported Living
Provider Time Sheet

Date	Enrollee's Name	Time In	Time Out	Total Units	Rate / Unit	Total Reimbursement	Guardian Initials (Under age of 18)
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)