Your email: *

☐ Check here to receive email updates

Your Name (Parent/Guardian/Designated Rep.) *

Your Phone Number *

Name of Individual receiving services *

Name of Support Worker *

Select service type Worker provided: *

Correct date and time of CLOCK IN *

Correct date and time of CLOCK OUT *

Activity Codes (does not apply to Enhanced Care Services or Overnight Respite) *

Reason for time change and other comments: *

I certify by submitting this form that I understand the following: As the self-directing Participant/Employer or Designated Representative, I assume all responsibility of employment of Direct Support Workers (DSWs), including assuring DSW work hours are submitted to the KS Authenticare system and are within the Participant/Employer's specific Plan of Care (or Integrated Service Plan). I understand Life Patterns, Inc. policies require time changes to be submitted within 48 hours of the date needing correction to ensure timely payment, that I may only submit a maximum of five (5) time changes per month per Participant/Employer, and that hours worked that exceed the Plan of Care are not billable to my Managed Care Organization and therefore will not be billed or paid by Life Patterns, Inc.

○ Agree