Life Patterns, Inc.

Time Change Form

The State requires written approval from the HCBS Waiver Participant for the claim to be corrected. This should only be used if the AuthentiCare system is not available.

This form is for incomplete shifts.

Full shifts cannot be submitted as the AuthentiCare system is required by KDADS.

Participant Name: _____

Direct Support Worker Name: _____

Worker ID_____

Date of Service: _____

Clock In Time: _____

Clock Out Time: _____

Activity Codes: _____

Place of Service Code: _____ (12-Home **OR** 99-Other Place of Service)

Reason for Correction: _____

_____

DSW Worker Signature: _____

Participant/Guardian/DR Signature: _____

*Note: If the DSW is the parent or Legal Guardian, the Designated Representative (DR) must sign and verify the Time Entry Change Form.

I certify, by submitting and signing 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 Integrated Service Plan (ISP). I understand Life Patterns, Inc. policies require time changes to be submitted within 48 hours of the date needing correction to ensure timely payment and that hours worked that exceed the ISP are not billable to my Managed Care Organization and therefore will not be billed or paid by Life Patterns, Inc.

Fax or email the form to within 48 hours of service.