LKiChoice
Part of the AssuranceSD family

Timesheet

It is your responsibility to verify that your completed and accurate timesheet has been received by LKiChoice once submitted via mail, fax, or email.
Please allow 48 hrs. before verification contact.

Employee Name: _____ **Person Receiving Services** (Member)**:** _____

Pay Period Beginning (MM/DD/YY): _____ **Pay Period Ending** (MM/DD/YY)**:** _____

ATTENTION: Timesheets received after the payroll schedule due date will be paid with the following payroll. NO EXCEPTIONS. LKiChoice is not responsible for paying hours that exceed the authorized hours. Falsification of this timesheet is considered Medicaid fraud and may result in dismissal from the program and/or criminal prosecution.

Date: Month/Day/Year	Service Code	Time In: Hour/Minute	AM/PM	Time Out: Hour/Minute	AM/PM	Total Hours Worked

Page _____ of _____ **Total hours for this page: _____**

Member/POA/Guardian

"I, the member or managing party, certify that the above employee worked the hours listed for this member, the services were provided in accordance with the care plan, and the member was NOT in a hospital, nursing home, or institution.

Signature: _____ Date signed: ____/_____/____

Employee

"I, the employee of this member, certify that the hours worked and listed for this member, were provided in accordance with the care plan, and the member was NOT in a hospital, nursing home, or institution.

Signature: _____ Date signed: ____/_____/____

Phone Number: _____ Email: _____

Please check your Funding Source:

❑MyChoice ❑CareWi (MCW) ❑ Independent Care - iCare ❑Inclusa ❑ Lakeland Care Inc
❑ Menominee ITOW ❑CLTS County: _____ ❑Other: _____

Submit Timesheet to LKiChoice at: 106 S Beaumont Rd, Prairie du Chien, WI 53821, Fax # 1-844-634-7225,
OR Payroll email: payroll@lkichoice.com
Website: www.lkichoice.com PH # 1-844-534-7225

OFFICE USE ONLY

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