



## Time Entry 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 HITT system is not available.

This form is for incomplete shifts.

**No Full Shifts can be added**

Participant Name: \_\_\_\_\_

Participant Medicaid ID #: \_\_\_\_\_

Direct Support Worker Name: \_\_\_\_\_

Worker ID#: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Clock In Time: \_\_\_\_\_

Clock Out Time: \_\_\_\_\_

Activity Codes: \_\_\_\_\_

Reason for Correction: \_\_\_\_\_

\_\_\_\_\_

**DSW Worker Signature:** \_\_\_\_\_

**Participant/Guardian/DR Signature:** \_\_\_\_\_

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

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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 Helpers, 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 Helpers, Inc.

Fax or scan and email the form to [help@helpersinc.org](mailto:help@helpersinc.org) within 48 hours of service.

[Help@helpersinc.org](mailto:Help@helpersinc.org)

Fax: (913) 322-7250