

Cost Center # _____

Day Services Attendance Sheet

For the month of:

Retain Copy at: (your company name & address)

Attendance Codes:

= # of hours attended day program

A = Absent

S = Saturday/Sunday

V = Vacation

-- = Not scheduled or placed

Directions: Please fill in the month, year, your company information, and cost center
ode in the spaces provided.

Please fill the name of the individual-last name first, in alphabetical order ~in the column
entitled client name.

Please fill the date of services with either of the following codes located at the left.

Please leave any days blank and sign and date the form.

Please submit the 1st and 2nd half of the month on separate forms.

If submitting multiple clients on one form, please use a separate form fir Clients with
different cost centers.

ABSENT: Indicate name, date, and departure and return time in the space provided.

New Reporting requirement is that the hours of service to be reported in ¼ hour unit. Please use 4 hour for 1 hour of service.
(Multiply full hours by 4 and for less than 1hour divide the minutes by 15. Report minimum 15 of minute increments or one unit).

Please use email button or send as attachment to: mzoccoli@communitybridgesnh.org Forward to Community Bridges Attn: Medicaid Billing, 2 Whitney Road, Concord, NH
03301 or Fax # 603-565-1092/603-223-9917. **Attendance is due no later than the 10th of the month for the 16th thru the end of the previous month and no later than the 20th
for the 1st thru the 15th of the current month.**

Signature

Date

Check Box and Enter Date when Maria Verifies
Check Box and Manager Name and Date when approved by Manager
Check Box and Date when sent to Business Office and By whom.