Pay Date:_____

Record Date:_____

ELITE COMMUNITY SERVICES, L.L.C.
Vocational, Tutoring & DDD Services
Toll Free: 888.558.1275 www.ECSAZ.org Fax: 480.558.1276

Billing Cover Sheet

Provider Name: _____

Provider Address:

_____

Street *city* *AZ* *zip*

Provider Phone Number: _____ Contact Information Recently changed: yes / no

Billing Period Month: _____ Billing Period Cycle: ☐ *1-15* ☐ *16-31*

Consumer Names **Hours Worked**

Note: attach separate time sheets for each consumer *Note: include total hours worked per service for entire cycle*

Last Name:	First Name:	Respite	Habilitation	Attendant Care	Respite Daily	ISE	ESA	Other
	Total Hours Submitted by Job Code:							
	Pay Rate:	X$	X$	X$	X$	X$	X$	X$
	Sub Total:							
		Total Pay:						

_____

Provider Signature **Date**

By signing, I agree all information is true for care provided. All hours above are true and accurate and represent all payments due for the pay period indicated. I understand any errors on my part will result in an adjustment of pay. I also understand that falsifying hours is grounds for immediate termination. Please print all areas clearly. Only signed, dated, and properly completed time sheets are to be turned in per designated schedules. Please make sure you have sent in all the required documents, have completed your online billing prior to submitting documents, and all is done prior to billing cutoff time which is 10:00 a.m.

No Auth:		Pay all or part on next billing cycle:	
Hours Used Before End of Auth:		Did not enter online billing:	
Missing/Incorrect Paperwork:		Addition Errors:	
Hours Worked Over Time Allowed/ Period Week:		Notified Coordinator/Date notified:	

Comments:

_____

_____