ABC HEALTH CARE
1234 Wayne Rd, Wayne MI 48184

EXHIBIT A

	Date	Time In	Time Out	HMK	PC	RC	PDN
SUN	9/27/2009	9:00 AM	5:00 PM	16	16		
	9/27/2009	5:00 PM	6:00 PM				4
	Client Signature: Jane Doe			TOT HMK 16	TOT PC 16	TOT RC	TOT PDN 4
MON	9/28/2009	3:00 PM	6:00 PM			12	
	Client Signature: Jane Doe					12	
TUES	9/29/2009	9:00 AM	5:00 PM	16	16		
	9/29/2009	5:00 PM	6:00 PM				4
	Client Signature: Jane Doe			TOT HMK 16	TOT PC 16	TOT RC	TOT PDN 4
WED							
	Client Signature:			TOT HMK	TOT PC	TOT RC	TOT PDN
THUR							
	Client Signature:			TOT HMK	TOT PC	TOT RC	TOT PDN
FRI							
	Client Signature:			TOT HMK	TOT PC	TOT RC	TOT PDN
SAT							
	Client Signature:			TOT HMK	TOT PC	TOT RC	TOT PDN

Client: JANE DOE

1. **Employee Name:** Mary Sue
2. **Employee Name:** Betty Lou, RN

Week Ending: 10/3/2009

Homemaking	SU	MO	TU	WE	TH	FR	SA
Clean Bathroom	X		X				
Change/Make Bed	X		X				
Clean Living Room							
Clean Appliances							
Dishes	X		X				
Clean Kitchen	X		X				
Meal Prep/Clean Up							
Laundry	X		X				
Dusting	X		X				
Sweep/mop/vacuum	X		X				
Empty Trash	X		X				
Shopping Errands							
Ironing/Mending							
Correspondence							
Other							
Personal Care	**SU**	**MO**	**SU**	**WE**	**TH**	**FR**	**SA**
Dietary Meals/Clean Up	X		X				
Dressing Grooming	X		X				
Bathing/Pers. Hygiene	X		X				
Toileting/Continence	X		X				
Mobility/Transfer Asst.							
Asst. Self Admin. Meds							
Med. Related HC Tasks							
Other							
Respite Hours	**SU**	**MO**	**TU**	**WE**	**TH**	**FR**	**SA**
Respite		X					
Private Duty Nursing	**SU**	**MO**	**TU**	**WE**	**TH**	**FR**	**SA**
PDN - RN	X		X				
PDN - LPN							
Chore	**SU**	**MO**	**TU**	**WE**	**TH**	**FR**	**SA**
Grass Cutting							
Snow Removal							
Fall Clean-Up							

Client Notes:

By signing below, I certify that this client received these services and all information is true and correct.

Mary Sue
Employee 1 Signature

Betty Lou, RN
Employee 2 Signature

Employee's Supervisor Signature

10/3/09
Date

EXHIBIT B

THE SENIOR ALLIANCE
MISSED VISIT LOG

Agency Name: ABC Health Care

Agency Contact Person: Krystal Reef

Agency Phone Number: (734) 555-1212

Month/Year: September, 2009

Vendor Codes:

PNA	Participant Not Available
PC	Participant Cancelled
PS	Participant Sick
PH	Participant Hospitalized
PNF	Participant in Nursing Facility
PDH	Participant Decreased Hours
PRW	Participant Refused Worker

VNS	Vendor/Worker – No Show
VS	Vendor/Worker Sick
VSP	Vendor/Worker Scheduling Problems
VNA	Vendor/Worker Not Available
VIW	Vendor Inclement Weather
VH	Vendor Holiday
	Client Priority Status: 1, 2, 3

Participant (Client) Name	Priority Status (1, 2, or 3)	Care Manager Name	Date of Missed Visit	Reason for Missed Visit (Use Codes)	Comments
Jane Doe	1	John Doe	9/30/2009	PNA	

ABC HEALTH CARE
1234 Wayne Rd, Wayne MI 48184
Transportation Log

EXHIBIT C

Date	Driver	Client Name	Time of Pick-Up	Mileage @ Pick-Up	Time of Drop Off	Mileage @ Drop-Off	Total # of Miles	Client Signature	Driver Initials
10/1/09	Flash Gordon	Jane Doe	9:30 AM	12345	12:10 PM	12359	14	Jane Doe	FG

EXHIBIT D

The Senior Alliance
Area Agency on Aging 1-C

DIRECT POS MONTHLY INVOICE SUMMARY REPORT

Month: September **Year:** 2009

Vendor: ABC Health Care **Telephone:** 734-555-1212

Fax: 734-555-1213

Service		Total Units		Unit Cost		Total
1.	HMK	32	X	$ 3.25	=	$ 104.00
2.	PC	32	X	$ 3.63	=	$ 116.16
3.	RC	12	X	$ 3.50	=	$ 42.00
4.	PDN	8	X	$ 9.00	=	$ 72.00
5.			X		=	$ -
6.			X		=	$ -
7.			X		=	$ -
8.			X		=	$ -
9.			X		=	$ -
10.			X		=	$ -
11.			X		=	$ -
12.			X		=	$ -
13.			X		=	$ -
14.			X		=	$ -
15.			X		=	$ -
(Use Additional Pages as Needed)					TOTAL DUE:	$ 334.16

Notes/Comments:

Signed: I certify that the expenditures being reported are correct and appropriate. Documentation to support these charges is available and maintained as required.

Lisa Wilson **Date:** 10/3/09

Must be Original Signature's Only

The Direct POS Monthly Invoice Summary Report is due in TSA's office *NO LATER THAN the 8th* of the month following the month in which the service was provided.

Revised 8/15/08

The Senior Alliance, Area Agency on Aging 1-C
POS Monthly Report/Invoice

EXHIBIT E

Month September, 2009 **Service Provider** ABC HEALTH CARE **Phone** 734-555-1212

Client's Name JANE DOE **Client's City/Township** WAYNE

Service **Fill in total units per day for each service that was provided.**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1. HMK																											16		16		
2. PC																											16		16		
3. PDN																											8				
4. RC																												12			
5.																															

PROVIDER'S USE:

SERVICE		Total Units		Unit Cost	Total
Service 1:	HMK	32	X	$ 3.25	$ 104.00
Service 2:	PC	32	X	$ 3.63	$ 116.16
Service 3:	PDN	8	X	$ 9.00	$ 72.00
Service 4:	RC	12	X	$ 3.50	$ 42.00
Service 5:	0	0	X		$ -
				TOTAL DUE:	$ 334.16

TSA USE:

Posted Date:

Invoice Number:

Notes/Comments (problems, deviations from service orders, etc.):

The Purchase of Service Report/Invoice forms (one for each client) **MUST** be submitted to TSA **NO LATER THAN** the 8th of each month following the month in which service was provided. I certify that the expenditures being reported are correct and appropriate. Documentation is available and will be maintained as required.

Signed: Lisa Wilson **Date:** 10/3/09

Revised 8/15/08