MFP Self-directed Waiver Services

FI Contact Information
STAVROS FISCAL INTERMEDIARY SERVICES
P.O. Box 2130, Amherst, MA 01004-2130
Tel: (413) 256-6692, (800) 442-1185
Fax: (888)773-4281, (413)256-3849

Payroll Period From Sunday / / Through Saturday / /

Employer Name Employer Number

☐ **Employer check only if new address, telephone, or e-mail and attach change form.**

DCW Name

DCW Social Security Number (Last 4 digits only)

☐ **DCW check only if new address, telephone, or e-mail and attach change form.**

Codes: 1 - Adult Companion 2 - Chore Service 3 - Homemaker 4 - Individual Support and Community Habilitation 5 - Personal Care 6 - Peer Support

Week 1	Code #	Time In	Time Out	Total
Sun.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Mon.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Tue.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Wed.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Thu.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Fri.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Sat.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		Total Hours for Week 1		:

By signing below, I certify under pain and penalty of perjury that I have received MassHealth self-directed services from the DCW during the times described on this activity form.

X _____ _____
Employer/Surrogate's Signature Date

Week 2	Code #	Time In	Time Out	Total
Sun.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Mon.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Tue.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Wed.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Thu.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Fri.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
Sat.		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		: ☐AM ☐PM	: ☐AM ☐PM	:
		Total Hours for Week 2		:

By signing below, I certify under pain and penalty of perjury that I have provided MassHealth self-directed services to the waiver participant during the times described on this activity form.

X _____ _____
DCW's Signature Date