



NC Alliance of Public Health Agencies, Inc.  
222 N. Person St, Suite 208  
Raleigh, NC 27601  
919-828-6204  
919-828-6203 (fax)  
[bhughes@ncapha.org](mailto:bhughes@ncapha.org)

Dear Alliance Employee,

Congratulations and welcome to the North Carolina Alliance of Public Health Agencies.

The Alliance payroll calendar and timesheets are included for you below. Some employees will be given timesheets customized for their specific position. If that is the case then please use the customized timesheet. Our pay periods run from the 1<sup>st</sup> day of the month through the 15<sup>th</sup> and the 16<sup>th</sup> through the last day of the month. Time worked should be recorded on the timesheet in .25 intervals (ex. 5 hours, 15 min = 5.25). Please refer to the payroll calendar for timesheet deadlines.

Also, please note that the timesheets contain a request for patient contact information. This is for those employees such as Dentists, Home Health Nurses, Social Workers, etc. who have direct patient contact. Please use the last column to record the total number of patient contacts and then summarize totals at the bottom. If you do not have direct patient contact, then please leave these lines blank.

**Time sheets received after the due date will be held and paid with the next check cycle.**

Please have the Agency **supervisor sign your time sheet** and either:

**Fax it to (919) 828-6203**

**OR**

**Scan and email it to [timesheet@ncapha.org](mailto:timesheet@ncapha.org)**

If you haven't already, please submit a **voided check** for set up of direct deposit as soon as possible and allow up to one month for direct deposit to become active. **Your first and possibly second check will be mailed!** Once direct deposit begins entry will be made to your account by the 10<sup>th</sup> and 25<sup>th</sup> of the month.

Please contact me with any payroll related questions or concerns at (919) 828-6204.

Sincerely,

Becky Hughes  
Finance Director

**NC Alliance of Public Health Agencies, Inc.**  
**2018 Payroll Calendar**

<b>Pay Period</b>	<b>Timesheets Must Be Received on the Date Listed Below</b>	<b>Pay Date</b>
December 16 - 31	January 2, 2018	January 10, 2018
January 1 - 15	January 16, 2018	January 25, 2018
January 16 - 31	February 1, 2018	February 9, 2018
February 1 - 15	February 16, 2018	February 23, 2018
February 16 - 28	March 1, 2018	March 9, 2018
March 1 - 15	March 16, 2018	March 23, 2018
March 16 - 31	April 2, 2018	April 10, 2018
April 1 - 15	April 16, 2018	April 25, 2018
April 16 - 30	May 1, 2018	May 10, 2018
May 1 - 15	May 16, 2018	May 25, 2018
May 16 - 31	June 1, 2018	June 8, 2018
June 1 - 15	June 18, 2018	June 25, 2018
June 16 - 30	July 2, 2018	July 10, 2018
July 1 - 15	July 16, 2018	July 25, 2018
July 16 - 31	August 1, 2018	August 10, 2018
August 1 - 15	August 16, 2018	August 24, 2018
August 16 - 31	September 4, 2018	September 10, 2018
September 1 - 15	September 17, 2018	September 25, 2018
September 16 - 30	October 1, 2018	October 10, 2018
October 1 - 15	October 16, 2018	October 25, 2018
October 16 - 31	November 1, 2018	November 9, 2018
November 1 - 15	November 16, 2018	November 23, 2018
November 16 - 30	December 3, 2018	December 10, 2018
December 1 - 15	December 17, 2018	December 21, 2018
December 16 - 31	January 2, 2019	January 10, 2019

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Month & Year: \_\_\_\_\_

County: \_\_\_\_\_

Date	Hours	Home Health Visits	Home Health Resumption Visits	Home Health Admission Visits	On - Call	Other:	Mileage	Paid Time Off	Number of Patient Contacts:
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
<b>TOTAL</b>									

Employee's Signature: \_\_\_\_\_

Total Patient Contacts: \_\_\_\_\_

Approved By: \_\_\_\_\_

Total Home Health Care Visits: \_\_\_\_\_

**\*\*\*Please remember to have your supervisor sign here!!!!**

Total Dental Patient Contacts: \_\_\_\_\_

**\*\*\* Also please remember to total your hours, visits, mileage, etc.**

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Month & Year: \_\_\_\_\_ County: \_\_\_\_\_

Date	Hours	Home Health Visits	Home Health Resumption Visits	Home Health Admission Visits	On - Call	Other:	Mileage	Paid Time Off	Number of Patient Contacts:
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
<b>TOTAL</b>									

Employee's Signature: \_\_\_\_\_ Total Patient Contacts: \_\_\_\_\_

Approved By: \_\_\_\_\_ Total Home Health Care Visits: \_\_\_\_\_

\*\*\*Please remember to have your supervisor sign here!!!! Total Dental Patient Contacts: \_\_\_\_\_

\*\*\*Also please remember to total your hours, visits, mileage, etc.