



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

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 1st day of the month through the 15th and the 16th 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

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 10th and 25th 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.
2019 Payroll Calendar

Pay Period	Timesheets Must Be Received on the Date Listed Below	Pay Date
December 16 - 31	January 2, 2019	January 10, 2019
January 1 - 15	January 16, 2019	January 25, 2019
January 16 - 31	February 1, 2019	February 8, 2019
February 1 - 15	February 18, 2019	February 25, 2019
February 16 - 28	March 1, 2019	March 8, 2019
March 1 - 15	March 18, 2019	March 25, 2019
March 16 - 31	April 1, 2019	April 10, 2019
April 1 - 15	April 16, 2019	April 25, 2019
April 16 - 30	May 1, 2019	May 10, 2019
May 1 - 15	May 16, 2019	May 24, 2019
May 16 - 31	June 3, 2019	June 10, 2019
June 1 - 15	June 17, 2019	June 25, 2019
June 16 - 30	July 1, 2019	July 10, 2019
July 1 - 15	July 16, 2019	July 25, 2019
July 16 - 31	August 1, 2019	August 9, 2019
August 1 - 15	August 16, 2019	August 23, 2019
August 16 - 31	September 3, 2019	September 10, 2019
September 1 - 15	September 16, 2019	September 25, 2019
September 16 - 30	October 1, 2019	October 10, 2019
October 1 - 15	October 16, 2019	October 25, 2019
October 16 - 31	November 1, 2019	November 8, 2019
November 1 - 15	November 18, 2019	November 25, 2019
November 16 - 30	December 2, 2019	December 10, 2019
December 1 - 15	December 16, 2019	December 23, 2019
December 16 - 31	January 2, 2020	January 10, 2020

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									
TOTAL									

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									
TOTAL									

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.