CRISIS PAY AUTHORIZATION

Need Assistance?
Call: 800-428-4471

Client Facility Name: _____ **Date Worked:** _____

Provider Name: _____

Full Shift Qualifies for Crisis Pay: ☐ Yes ☐ No ☐ Partial Shift

Number of Hours Worked That Qualify[1] for Crisis Pay _____

*__Provider Signature:__ _____ **Date:** _____

__Client Facility Authorization (Print):__ _____ **Signature: _____

Client Contact Phone Number: _____ **Date:** _____

Email completed form to: expresspay@staffhealth.com

[1] Observation units may not be considered crisis pay, contact scheduler.
* I certify that the hours shown above represent my total hours worked and the Facility Approval was initiated by the Facility or an Authorized Representative of the Facility. I will return this signed timesheet within 7 days.
** I certify that the hours shown above are correct and that the above identified healthcare professional performed satisfactorily.