

RESPITE

Ratio: _____ : _____

Provider Name: _____ (PRINT NAME)

Month/ Year: _____

Client Name: _____ (PRINT NAME)

- ◆ Time Sheets will not be processed without both the signatures at the bottom
- ◆ Time entries must be rounded off to the nearest Quarter hour
- ◆ Parent/Guardian must initial mistakes or mark-outs
- ◆ Only fill in dates/times that you have worked, other dates Total Hours should be marked "0"

FAX TO: 623-505-9623

OR

Email To peoriafax@azcareproviders.com

Work Day	Date	Time In	Time Out	Total Hours	Work Day	Date	Time In	Time Out	Total Hours
SUNDAY		a.m.	a.m.		SUNDAY		a.m.	a.m.	
		p.m.	p.m.				p.m.	p.m.	
MONDAY		a.m.	a.m.		MONDAY		a.m.	a.m.	
		p.m.	p.m.				p.m.	p.m.	
TUESDAY		a.m.	a.m.		TUESDAY		a.m.	a.m.	
		p.m.	p.m.				p.m.	p.m.	
WEDNESDAY		a.m.	a.m.		WEDNESDAY		a.m.	a.m.	
		p.m.	p.m.				p.m.	p.m.	
THURSDAY		a.m.	a.m.		THURSDAY		a.m.	a.m.	
		p.m.	p.m.				p.m.	p.m.	
FRIDAY		a.m.	a.m.		FRIDAY		a.m.	a.m.	
		p.m.	p.m.				p.m.	p.m.	
SATURDAY		a.m.	a.m.		SATURDAY		a.m.	a.m.	
		p.m.	p.m.				p.m.	p.m.	
TOTAL HOURS					TOTAL HOURS				

** Respite should NOT EXCEED 12 hours in a 24 hour period.

** No Billing if Member is in the Hospital

Provider's Signature _____

Date: _____

Parent/ Guardian's Signature _____

Date: _____