

Respite Hours Time Sheet

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Name:		Month:	
Address:		Phone Number:	
Child(ren):		Program:	Respite

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Full Days (overnight)															
Half Days															

	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Full Days (overnight)																
Half Days																

**Please submit to
Lauren Wimer by the
10th of each month.**

Non-Specialized Full Days: _____ x \$35.00 x number of children: _____ = _____

Specialized Full Days: _____ x \$45.00 x number of children: _____ = _____

Non-Specialized Half Days: _____ x \$17.50 x number of children: _____ = _____

Specialized Half Days: _____ x \$22.50 x number of children: _____ = _____

Total = _____

Respite Provider Signature
Respite Coordinator Signature

*Agency Use Only	Date received:	Case Number:	Case Worker:
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