

Human Resource Center, Inc.

May 2018

Habilitation Temporary Respite Companion 24 hr Respite

Support Worker: _____

Address: _____

Telephone #: _____

Individuals Name: _____ Rate: _____

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
	1 Start time _____ End Time _____ Total Hrs. _____	2 Start time _____ End Time _____ Total Hrs. _____	3 Start time _____ End Time _____ Total Hrs. _____	4 Start time _____ End Time _____ Total Hrs. _____	5 Start time _____ End Time _____ Total Hrs. _____	6 Start time _____ End Time _____ Total Hrs. _____	Total Wk. Hrs. _____
7 Start time _____ End Time _____ Total Hrs. _____	8 Start time _____ End Time _____ Total Hrs. _____	9 Start time _____ End Time _____ Total Hrs. _____	10 Start time _____ End Time _____ Total Hrs. _____	11 Start time _____ End Time _____ Total Hrs. _____	12 Start time _____ End Time _____ Total Hrs. _____	13 Start time _____ End Time _____ Total Hrs. _____	Total Wk. Hrs. _____
14 Start time _____ End Time _____ Total Hrs. _____	15 Start time _____ End Time _____ Total Hrs. _____	16 Start time _____ End Time _____ Total Hrs. _____	17 Start time _____ End Time _____ Total Hrs. _____	18 Start time _____ End Time _____ Total Hrs. _____	19 Start time _____ End Time _____ Total Hrs. _____	20 Start time _____ End Time _____ Total Hrs. _____	Total Wk. Hrs. _____
21 Start time _____ End Time _____ Total Hrs. _____	22 Start time _____ End Time _____ Total Hrs. _____	23 Start time _____ End Time _____ Total Hrs. _____	24 Start time _____ End Time _____ Total Hrs. _____	25 Start time _____ End Time _____ Total Hrs. _____	26 Start time _____ End Time _____ Total Hrs. _____	27 Start time _____ End Time _____ Total Hrs. _____	Total Wk. Hrs. _____
28 Start time _____ End Time _____ Total Hrs. _____	29 Start time _____ End Time _____ Total Hrs. _____	30 Start time _____ End Time _____ Total Hrs. _____	31 Start time _____ End Time _____ Total Hrs. _____				Total Wk. Hrs. _____

Total Cost : \$ _____
Total Hrs for the Month : _____

Employee Signature- _____ Date- _____

Approved by - _____ Date- _____

Relationship to Consumer - _____

** (Invoices must be **approved/verified** by the Consumer himself/herself, or Primary Caretaker **before** it is submitted for payment. Invoices that are not signed cannot be paid.)

Signed invoices must be received in our office by the Fifth (5th) of each month:

Payroll Specialist - or fax to: **(570) 872-9959**
Human Resources Center, Inc.
PO Box 77
Effort, PA 18330