Human Resource Center, Inc.
August 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. __________	Total Wk. Hrs. __________
6 Start time End Time Total 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. __________	Total Wk. Hrs. __________
13 Start time End Time Total 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. __________	Total Wk. Hrs. __________
20 Start time End Time Total 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. __________	Total Wk. Hrs. __________
27 Start time End Time Total 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