

Respite Hours Time Sheet

Name: _____

Month: _____

Address: _____

Program: **Respite**

_____ phone: _____

Children: _____

	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
Becky Orebaugh 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