Arizona Care Providers
Quality Care with a Difference !!

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: 623-218-1216
OR
Email To fax@azcareproviders.com

Work Day	Date	Time In	Time Out	Total Hours	Work Day	Date	Time In	Time Out	Total Hours
SUNDAY		a.m. / p.m.	a.m. / p.m.		SUNDAY		a.m. / p.m.	a.m. / p.m.	
MONDAY		a.m. / p.m.	a.m. / p.m.		MONDAY		a.m. / p.m.	a.m. / p.m.	
TUESDAY		a.m. / p.m.	a.m. / p.m.		TUESDAY		a.m. / p.m.	a.m. / p.m.	
WEDNESDAY		a.m. / p.m.	a.m. / p.m.		WEDNESDAY		a.m. / p.m.	a.m. / p.m.	
THURSDAY		a.m. / p.m.	a.m. / p.m.		THURSDAY		a.m. / p.m.	a.m. / p.m.	
FRIDAY		a.m. / p.m.	a.m. / p.m.		FRIDAY		a.m. / p.m.	a.m. / p.m.	
SATURDAY		a.m. / p.m.	a.m. / p.m.		SATURDAY		a.m. / p.m.	a.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:_____