**Please check consumer’s funding source:** **[ ]  Grant** **[ ]  Medicaid**

**For Office Use Only**

\_\_\_Tracked \_\_\_ Billed \_\_\_Initials

Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pay Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Key: In-Home Support (IH), Supported Living (SL), Day Habilitation (DH), Hourly Respite (HR)**

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| --- | --- | --- | --- | --- | --- | --- |
| **Initials of parent or person taking over** | **Date** | **Time In** | **Time Out** | **Total Hours** | **Service** | **Sibling care (Y/N)****(grant respite only)** |
|  |  |  |  |  | [ ]  IH/SL [ ]  DH [ ]  HR |  |
|  |  |  |  |  | [ ]  IH/SL [ ]  DH [ ]  HR |  |
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I give permission for the provider to provide care and administer medication to my child for this pay period. I understand that all overtime hours (or services on a CSS holiday) must be **pre-approved** by the Program Director. I confirm that the hours indicated above were worked by the provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature Date

**Key: In-Home Support (IH), Supported Living (SL), Day Habilitation (DH), Hourly Respite**

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| --- | --- | --- | --- | --- | --- | --- |
| **Initials of parent or person taking over** | **Date** | **Time In** | **Time Out** | **Total Hours** | **Service** | **Sibling care (Y/N)****(grant respite only)** |
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