The New Beginnings

Substitute Care/Respite Billing Sheet

Individual's Name: ____

Provider's Name: ______________________________

Month: ____________________________ Year: _______________________

Day	Time In	Time Out	Time In	Time Out	Total Hours	Respite Signature
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
					Total Billable Hours	

Note: Only 20 hours can be billed for a 24 hour period unless approved by IDT.

____ _________________________________

Home Base Provider Signature Date Coordinator's Signature Date