

Deliver no later than 1/1/2024 @ 12:00 PM BY:

E-Mail: timesheets@caringfamilysupports.org OR TEXT (213)304-2699 OR FAX (213)896-7033

EMPLOYEE NAME: _____ CLIENT NAME: _____

RESPIRE CARE:

	TIME IN	TIME OUT	TOTAL	OFFICE USE
FRI,12/1				
SAT,12/2				
SUN,12/3				
MON,12/4				
TUE,12/5				
WED,12/6				
THU,12/7				
FRI,12/8				
SAT,12/9				
SUN,12/10				
MON,12/11				
TUE,12/12				
WED,12/13				
THU,12/14				
FRI,12/15				
SAT,12/16				
SUN,12/17				
MON,12/18				
TUE,12/19				
WED,12/20				
THU,12/21				
FRI,12/22				
SAT,12/23				
SUN,12/24				
MON,12/25				
TUE,12/26				
WED,12/27				
THU,12/28				
FRI,12/29				
SAT,12/30				
SUN,12/31				
TOTAL				

DAY CARE/P.A:

DATE	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL	OFFICE USE
FRI,12/1						
SAT,12/2						
SUN,12/3						
MON,12/4						
TUE,12/5						
WED,12/6						
THU,12/7						
FRI,12/8						
SAT,12/9						
SUN,12/10						
MON,12/11						
TUE,12/12						
WED,12/13						
THU,12/14						
FRI,12/15						
SAT,12/16						
SUN,12/17						
MON,12/18						
TUE,12/19						
WED,12/20						
THU,12/21						
FRI,12/22						
SAT,12/23						
SUN,12/24						
MON,12/25						
TUE,12/26						
WED,12/27						
THU,12/28						
FRI,12/29						
SAT,12/30						
SUN,12/31						
TOTAL						

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 All time sheets need to be in the office by the **1st** of every month NOON PST. Late time sheets will be paid next month.

I declare, under perjury, that the above listed hours were worked by me for the client name. I complied with all the rules and regulations of the agency and sustained no injury this work period. I took all appropriate meal breaks and rest period.

Employee Signature: _____ Date: _____

I confirmed that the above total hours are accurate and the Caring Family Supports, INC. care provider performed their duties as outlined to my satisfaction.

Parent Signature: _____ Date: _____