



FAMILY RESPITE SERVICES PROOF OF SERVICE

| | |
|--|--|
| 3295 Quality Way, Unit 101A PHONE: 519-972-9688 | Windsor, ON N8T 3R9 FAX: 519-972-8902 |
|--|--|

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

PARENT'S NAME: _____

CHILD'S NAME: _____

RESPITE PROVIDER'S NAME: _____

FAMILY COORDINATOR: _____

PAY PERIOD END DATE _____

****TIMESHEETS ARE DUE EVERY OTHER WEDNESDAY BY 4:00PM****

| | | | | FOR OFFICE USE ONLY | |
|---------------------|------------------|-------------------------------|----------------------------------|---------------------|----------|
| DATE | # HOURS PROVIDED | INITIALED BY RESPITE PROVIDER | ACTIVITIES DURING RESPITE PERIOD | RATE | SVC TYPE |
| Sun | | | | | |
| Mon | | | | | |
| Tues | | | | | |
| Wed | | | | | |
| Thur | | | | | |
| Fri | | | | | |
| Sat | | | | | |
| Sun | | | | | |
| Mon | | | | | |
| Tues | | | | | |
| Wed | | | | | |
| Thur | | | | | |
| Fri | | | | | |
| Sat | | | | | |
| TOTAL HOURS: | | | TOTAL: | \$ | |

I verify that these respite services were provided for me. I have been authorized by Family Respite Services to use these services. I am invoicing FRS for the funds which I have paid to my respite provider/caregiver.

Signature of Parent/ Guardian: _____ Date: _____

Signature of Respite Provider: _____ Date: _____