PERSONAL ASSISTANT

EMPLOYEE must complete this time card, sign and date- **IN INK (Black)** **VENDOR** must verify dates of service, and sign date below and return this form to the regional center along with the signed Provider Care Claim. Payment cannot be made without proper completion and receipt of this timecard attached to the invoice/ claim.

EMPLOYEE MUST COMPLETE ALL INFORMATION

UCI# (PLEASE PRINT)

CLIENT NAME(CONSUMIDOR):	**ADDRESS/CITY/ZIPCODE(Dirección)**
NAME OR VENDOR:	**IN- ROADS**
ADDRESS:	7955 Webster St. Suite 14 Highland CA. 92346
TELEPHONE#:	(909)864-1551
NAME OF EMPLOYEE(EMPLEADO): (PLEASE PRINT)	

Date of Service: Month / Day / year **(Fecha)**	**Starting Time:** A.M / P.M (Round to nearest ¼ hour)	**Ending Time:** A.M / P.M (Round to nearest ¼ hour)	**Total Hours: (Horas)**	**Client Parent /Guardian Signature: (Firma De Padres)**

TOTAL HOURS/HORAS: _____

I certify that I provided non-medical "in-home" respite service to the client at the respite site indicated above and that the hours shown above represent the total hours worked during the month.

_____

EMPLOYEE/EMPLEADO SIGNATURE/ TITLE DATE/FECHA SIGNED

(Office use only)(Uso de oficina)

I certify that the Employee completing the above time card was employed trained, monitored, and assigned all duties solely by me. I further certify that the hours shown above are correct, that the Employee regularly performed satisfactorily, and met the TERMS AND CONDITIONS set forth in the vendor regulations.

_____

VENDOR SIGNATURE/TITLE (Do not complete, office use only) DATE SIGNED