IDEAL CARE LLC

Individual Client Billing Document

Month/*Mes*: ____________________ **Year/*Año*:** ____________________

Page/*Pagina*: _______ ***of*** _______

Provider Name/*Nombre de Proveedor/a:*	Provider Phone #/*Telefono de Proveedor/a:*	Pay Period Ending Date / Fecha Final de Pago
Client Name/*Nombre De Consumidor*	Phone #/*Telefono de Consumidor*	FOCUS ID:*/ **# Identificacion***

Client Address/*Direccion de Consumidor* City/*Ciudad* State/*Estado* Zip Code/*Zona Postal*

REMEMBER: YOU CAN INITIALLY FAX YOUR TIMESHEET – BUT YOU ARE STILL RESPONSIBLE TO TURN IN THE **ORIGINAL COPY**!
RECUERDA: PUEDES MANDAR FAX TU TIMESHEET – PERO ES TU RESPONSABILIDAD DE ENTRGAR LA **COPIA ORIGINAL** TAMBIEN!

Time sheets are due on the 1st and 16th before 4:00pm / Time sheets deben ser entegados a tiempo cada 1ro y 16to de cada mes antes de las 4:00pm!

Date	*Time In*	*Time Out*	*TOTAL* HAH	*TOTAL* ATC	*TOTAL* RSP 1	*TOTAL* RSP 2	*TOTAL* RSP 3	*RP INITIAL*
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
	AM PM	AM PM						
Totals								

*****DISCLAIMER*****

VIOLATIONS OF IDEAL CARE RULES AND POLICIES MAY RESULT IN TERMINATION OF EMPLOYMENT.

IT IS THE RESPONSIBILITY OF THE CONSUMER/S AND/OR GUARDIAN/S TO SUBMIT A TRUTHFULL AND AND TIMELY TIMESHEET FOR PAYMENT.

IDEAL CARE LLC DOES NOT RECOMMEND OR CONDONE PARENTS/GUARDIANS PROVIDING KEYS TO HOMES OR LOANING PERSONAL ITEMS TO PROVIDERS AND WILL NOT TAKE RESPONSIBILITY FOR REPLACEMENT.

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jose@idealcarellc.com

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gabby@idealcarellc.com

ADAM (623) 341-2210
adam@idealcarellc.com

Provider Signature/ *Firma de Proveedor/a:* ________________________________ **Date/*Fecha:*** ____________

Responsible Person's Signature/*Firma de Padres:* ________________________________ **Date/*Fecha:*** ____________

IDEAL Supervisor/ *IDEAL Supervisor/a:* ________________________________ **Date/*Fecha:*** ____________

Do not initial and/or sign until after services have been provided. By signing, the provider and responsible person certify the hours of service are correct. Billing Document must be legible and accurate for payment to be made. Services can only be provided to the individual listed on the authorization form. IDEAL CARE LLC is not responsible to pay for services provided in excess of those authorized for this individual/for ANY Pay Periods.

Use BLUE or BLACK ink only, and DO NOT use white out or cross out information … Usa tinta AZUL o NEGRA y NO taches informacion.