

Employee's Name (Respite Provider): _____ Phone: _____

Client Name: _____

Client's Representative _____ County _____

2-Week Pay Period: **Sunday** ___/___/___ **Thru Saturday** ___/___/___

Was the client **hospitalized** during this pay period? **Yes No**

If yes, dates hospitalized: **from** _____ **to** _____ **Time of day** Client admitted to hospital _____ (**am or pm**)

Sleeping time—how to record it according to Labor Law:

1. If the respite provider is **working for less than 24 hours**, and their work time **includes sleeping**, he/she must be paid for **all** hours of work including sleep time.
2. If the respite provider is **working for 24 hours or more**, **GENERALLY*** he/she is **not paid** for the 8 hours of 10pm to 6am (this is the standard typically used for sleep time).
3. However, if the respite provider is **not** able to get **5 continuous hours of sleep** because of assistance needed by the client, the respite provider must be paid for all of the hours through the night.

***After reviewing the policies on sleeping time, please indicate below how the respite provider will be paid if he/she works 24 hours or more:**

___ **Pay** for sleeping time ___ **Do not pay** for sleeping time

Date	Time the hourly respite started	Time the hourly respite ended	Total hours worked each time		Date	Time the hourly respite started	Time the hourly respite ended	Total hours worked each time
	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	

This respite is: ___ **in-home** (in the client's home)
 ___ **out-of-home** (in someone else's home)

Hourly respite rate: \$ _____ per hour

Total hours: _____

In addition to verifying the hours worked, my signature indicates that I have read and understand the Department of Labor Rules regarding respite as stated above, and this is an agreement between the Client/Client Rep and Respite Provider to non-payment of 8 hours if sleep time is excluded.

Signature of Respite Provider

Signature of Client/Client's Representative

Date

Date

BOTH PROVIDER AND CLIENT/CLIENT'S REPRESENTATIVE MUST SIGN