**Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DDS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*Respite/Personal Support/IHS provider payments made prior to the grant request date or after the allowable reporting period will not be accepted.

**\*Respite services over 13 consecutive hours in a 24-hour period must use a daily rate. Contact your case manager for more information about the rates.**

\*Staff must be paid not less than the state minimum wage.

\*Any changes to your approved grant must be submitted to DDS Grant Manager for review and approval prior to the changes occurring.

\*Please fill out each line completely. Do not use arrows to show the same rate, person, etc.

\*Please make sure the staff information (name, address, phone #) appears on each log submitted.

**Payee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Payee signature and date above indicate that you have reviewed the information below and it is accurate)**

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| --- | --- | --- |
| **Respite/Personal Support/IHS Providers’ Information** | | |
| **Name** | **Address** | **Phone Number** |
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| **Date**  **Service**  **Provided** | **Scheduled Times Worked** | **Total Hours Provided**  **(¼ hour increments)** | **Hourly Rate** | **Total Paid to the Provider Today** | **Provider Name** | **Provider Signature**  **(*required on each line*)**  **Signature indicates payment received** |
| ***Sample***  ***01/01/18*** | ***Sample***  ***3:45pm-8pm*** | ***Sample***  ***4.25 Hours*** | ***Sample***  ***$11.00*** | ***Sample***  ***$46.75*** | ***Sample***  **John Smith** | ***Sample***  ***John Smith*** |
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**Page Total $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DDS Designee Only)**