

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**