

ARION CARE SOLUTIONS, LLC EMPLOYEE BILLING DOCUMENT

Employee Name: _____ Client Name: _____
 Area Manager: _____ Month/YR: _____

DISCLAIMER FOR TRANSPORTING CONSUMERS IN ANY VEHICLE, EMPLOYEE'S MUST HAVE PRIOR APPROVAL AND CARRY CURRENT PROOF OF INSURANCE & REGISTRATION AT ALL TIMES & THIS INFORMATION MUST BE COPIED TO THE EMPLOYEE FILE.

| Date | Attendant Care Hours ANC or AFC | | | | Habilitation Hours HAH or HAI | | | | Respite Hours RSP | | | | Responsible person approval; (initial) |
|------|---------------------------------|----------|--------------|--------------|-------------------------------|----------|--------------|--------------|-------------------|----------|--------------|--------------|---|
| | Time In | Time Out | Hours Worked | POS 12 0r 99 | Time In | Time Out | Hours Worked | POS 12 0r 99 | Time In | Time Out | Hours Worked | POS 12 0r 99 | |
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| | | | Total | | | | Total | | | | Total | | |

Employee Signature/Date: _____ Total hours verified by Responsible Party

Responsible Person Signature/Date: _____
 Sign above after the entries are accurate and have been carried out and you understand the disclaimer statement. RP is financially responsible for over usage of hours at contracted rate. Please do not sign prior to time sheet being fully completed.