KNUCWENTWECW SOCIETY

RESPITE/RELIEF CARE

Monthly Occupancy Report and Billing

Name of Resource	☐ Relief Care ☐ Respite Care Do not combine, if billing for both, use 1 form for each	FAMILY CARE HOME ☐ Regular ☐ Level 1 ☐ Level 3 ☐ Restricted ☐ Level 2	OTHER ☐ Group Home ☐ Specialized Resource	Month of
Address of Resource	OR ☐ SPMH ☐ CF&CS			

Use ONLY If Per Diem Varies

Liaison Worker Only IN CARE BY

Name of Child	Birth Date	Sex	Child Placed By	Relationship	Dates Services Provided	Total Days	X Agreed Per Diem	Total
					1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31			
					1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31			
					1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31			
					1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31			
					1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31			
					1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31			
					1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31			
					TOTAL DAYS PAYABLE ⇒ X AGREED PER DIEM OF $_ = TOTAL BILLING⇒			**TOTAL**

Authorized for payment

Liaison/Social Worker	Date

I certify that this is a true and accurate statement of the Care provided to the clients listed above

Caregiver/Resource Operator	Date

Spending Authority - Certified that the amount to be paid is correct, is in accordance with appropriate statue or other authority for payment and/or contract; and, where applicable, other conditions have been met; I as spending authority, will monitor contract performance and advise the financial services division of termination or breach of contract

Print Name _____ Spending Authority Signature _____ Date _____

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