

PROGRAM / FUNDING

Program (check one): ☐ FSCD — Family Support for Children with Disabilities ☐ PDD — Persons with Developmental Disabilities

CLIENT INFORMATION

Client Name:
File #:

STAFF INFORMATION

Staff Name:
Pay Rate (\$/hr):
Position / Role:
Address:

PAY PERIOD

Pay Period Start Date:
Pay Period End Date:
Submitted Date:

DAILY HOURS LOG

Date	Day	Time In	Time Out	Break (mins)	Total Hours	Service Type / Activity Code	Initials
	Mon						
	Tue						
	Wed						
	Thu						
	Fri						
	Sat						
	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
	Fri						
	Sat						
	Sun						
TOTALS							

Codes: PC = Personal Care | CM = Community Access | BH = Behaviour Support | RS = Respite | LS = Life Skills | OT = Other

MILEAGE / EXPENSES (IF APPLICABLE)

Date	Description / Purpose	Km / Amount (\$)	Receipt?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

SIGNATURES

Staff Signature
Printed Name:
Date:

FMS Administrator Signature
Printed Name:
Date:

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