CAREGIVERS INVOICE

Phone (954) 722-7662 **Fax (954) 765-6955** **Email: invoice@caregiversofamerica.com**

Independent Contractor
(Caregiver)_____
(print your name clearly)

Referral
(Client) _____
(print client's name clearly)

Please use new time sheet for next day of new week ➡

Day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Date							
Start time	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Finish Time	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Total Hours Worked							
Client/Guardian Initials							
Activities must be checked for each day							
Bathing Assistance							
Dressing Assistance							
Toileting Assistance							
Incontinent							
Assistance with Transfers							
Assistance with Spoon Feeding							
Homemaker Services							
B=Bedbound W=Walker W/C-Wheelchair C=Cane							
Mental Status: C = Cognitive Impairment							

Notes: _____
_____
_____
_____

By signing below, Caregiver and Client hereby affirm that the hours reflected on this invoice are true and correct and may be relied upon as such by the referring registry. Client hereby authorizes the preparation of an invoice reflecting these hours at the Caregiver pay rate that was determined and agreed to by Client and Caregiver. To ensure the preparation of accurate invoices, Client and/or Caregiver will inform the referring registry about any change in the Caregiver pay rate to which they mutually agree.

Independent Contractor: _____
(Signature required)

Referral/Client's Signature: _____
(Signature required)