Please PRINT in black ink **MRCI**

Hourly Respite

Employee's Name (Respite Provider)_____Daytime 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**

BOTH PROVIDER AND CLIENT/CLIENT'S REPRESENTATIVE MUST SIGN

Fax Toll Free using 1-888-800-7336
If faxing, please do not mail
OR, scan and email to payroll@mrciworksource.org

FOR OFFICE USE ONLY:
Total wages = _____
P.P.E. _____
_____ Spreadsheet