



SINCERE HOME CARE
REAL PEOPLE. SUPREME SUPPORT.

Hourly Respite Time Report

EMAIL TO: timecards@sincerehomecaremn.com or FAX: (763) 208 – 6089

Employee's Name (Respite Staff) _____

Daytime Phone # _____

Client Name _____

County _____

Responsible Party _____

2-Week Pay Period

Monday ___/___/___ thru Sunday ___/___/___

Was the Client hospitalized during this pay period? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, dates hospitalized: from _____ to _____
Time of day Client admitted to the hospital _____ am/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	
	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: \$11.75 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, Responsible Party, and Respite Staff to non-payment of 8 hours of if sleep time is excluded.

Signature of Respite Staff

Signature of Client/Responsible Party

BOTH RESPITE STAFF AND CLIENT/RESPONSIBLE PARTY MUST SIGN