MUST BE RETURNED BY THE 1ST DAY OF EACH MONTH
Mail to: 1595 Bay St. Victoria BC V8R 2B5
Fax to: (250) 389-1110 Email to: billing@cocf.ca

STAMP DATE RECEIVED HERE

INVOICE FOR THE MONTH(S) OF _____
(please include all respite dates from the first to the last day of the month)

CONTRACTOR / PAYEE _____

ADDRESS _____
(STREET, CITY, POSTAL CODE) **please indicate** (NEW / CHANGE of ADDRESS) YES □ NO □

PHONE NUMBER (daytime) _____ **(home)** _____

NAME _____ **CHILD** □ **ADULT** □ **RATE per DAY** $_____

		A	B	C	E	F	G		
START DATE & START TIME (am or pm)	**END DATE & END TIME** (am or pm)	**NUMBER OF DAYS** (9-24hr) = 1 DAY	**RATE per DAY**	**SUB-TOTAL A x B**	**HOURS** ENTER BETWEEN 0-9 HRS.	**RATE per BLOCK** *hourly if applicable*	**SUB-TOTAL BLOCK** *(E x F if hourly rate)*	**TOTAL BILLED** **C + G**	**PARENT** GUARDIAN **INITIALS**
AM PM	AM PM								
AM PM	AM PM								
AM PM	AM PM								
AM PM	AM PM								
AM PM	AM PM								
AM PM	AM PM								

If more space is please attach a separate sheet.
required to complete items 1 - 5 below, **TOTAL BILLED$**_____

1. List the activities you and the child/adult participated in during respite:
2. Were there any changes in care needs during this respite period? (i.e. health, safety, behaviors) If yes, please describe on separate sheet.
3. Are there any areas where you need additional support when providing respite? If yes, when is the best time to contact you? For more space, use separate sheet.
4. Was an Incident Report submitted during this respite period? Yes ☐ No ☐

5. **Caregiver comments:**	**Adult or Child comments:**	**Parent / Guardian comments:**

FOR OFFICE USE ONLY
Payment Approval _____ Coordinator Approval_____ Chq/DD #_____ Date_____

Date Posted Access_____