INLAND RESPITE INC.

10800 Hole Ave, Suite 10, Riverside, CA 92505
Tel. (951) 353-1261 Fax: (951) 689-2878

MONTHLY SCHEDULE

I, _____ Parent/Caregiver of _____
(Print Parent's/Caregiver Name) Child's Name

I agree to provide this agency, a monthly schedule since I have a respite worker

_____. I understand that it is my responsibility to call the
Respite Worker's Name

Receptionist/scheduler when I decide to change the schedule after I have submitted the Monthly Schedule to your office.
I also agree to pay for all hours that I have used over the hours allowed by the Regional Center. I agree to pay the billing invoice within 30 days of receiving the billing invoice

MONTH: _____

Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm
Date: _____ Time: From: _____ am / pm To: _____ am / pm

Comments:

_____

_____

_____ _____
Parent / Caregiver Signature **Date**