

ORION ISO, INC

Personal Supports

Consumer Name: _____

Employee Name: _____

Month: _____

Due Date: 19th of the month

County: _____

Service Type Guide:

REG - Personal Supports

TRN- Training hours

HOM-Homemaker

INR- In-Home Respite, OHR-Out of Home Respite

TRV = Travel Time - must be travel between 2 consumers homes.

Date	Shift Start am/pm	Shift End am/pm	Service Type	Shift Start am/pm	Shift End am/pm	Service Type		Travel Time	Travel Start am/pm	Travel End am/pm	Total Hours	RESP code sleep det. applies: Y or N
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Comments: _____

Summary of Service Types		Personal Support				TRV	Total Hours
Summary of Hours per Service Type							

Total OVT Hrs.

*FOR OFFICE USE ONLY

I certify, that this is an accurate record of the services I have provided.

Employee Signature: _____ *required

Date: _____

I certify, that this is an accurate record of the services this employee has provided.

Employers Signature: _____

Date: _____

Employer Phone #: _____ *required

Fax Toll Free: 1-877-677-3314

E-mail: Payroll@orionassoc.net

Mail to: Orion ISO, Inc

Attn: Payroll

**9400 Golden Valley Road
Golden Valley, MN 55427**

Contacts:

Consumers A - L 763-450-5191

Consumers M - Z 763-450-5195

ORION ISO, INC

Personal Supports

Consumer Name: _____

Employee Name: _____

Month: _____

Due Date: 4th of the month

County: _____

Service Type Guide:

REG - Personal Supports

TRN- Training hours

HOM-Homemaker

INR- In-Home Respite, OHR-Out of Home Respite

TRV = Travel Time - must be travel between 2 consumers homes.

Date	Shift Start am/pm	Shift End am/pm	Service Type	Shift Start am/pm	Shift End am/pm	Service Type	Travel Time	Travel Start am/pm	Travel End am/pm	Total Hours	RESP code sleep dist: applies: Y or N
16											
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											

Comments:

Summary of Service Types		Personal Support				TRV	Total Hours
Summary of Hours per Service Type							

Total OVT Hrs.

*FOR OFFICE USE ONLY

I certify, that this is an accurate record of the services I have provided.

Employee Signature: _____ *required

Date: _____

I certify, that this is an accurate record of the services this employee has provided.

Employers Signature: _____

Date: _____

Employer Phone #: _____ *required

Fax Toll Free: 1-877-677-3314

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Mail to: Orion ISO, Inc

**Attn: Payroll
9400 Golden Valley Road
Golden Valley, MN 55427**

**Contacts:
Consumers A - L 763-450-5191
Consumers M - Z 763-450-5195**

ORION ISO, INC

Personal Supports

Consumer Name: _____

Employee Name: _____

Month: _____

Month of hours reports
Due Date: 19th of the month

County: County consumer lives in

Service Type Guide:

REG - Personal Supports

TRN- Training hours

HOM-Homemaker

INR- In-Home Respite, OHR-Out of Home Respite

TRV = Travel Time - must be travel between 2 consumers homes.

Date	Shift Start am/pm	Shift End am/pm	Service Type	Shift Start am/pm	Shift End am/pm	Service Type		Travel Time	Travel Start am/pm	Travel End am/pm	Total Hours	
1	9:00am	5:00pm	REG					TRV	5:00pm	5:30pm	8.5	
2												
3	1:00pm	2:00pm	TRN								2.00	
4	SAMPLE											
5												
6	10:00pm	12:00am	INR								2.00	
7	12:00am	10:00pm	INR								22.00	Y
8												
9												
10												
11												
12	6:00pm	12:00am	INR								6.00	N
13	12:00am	8:00am	INR								8.00	N
14												
15												

RESP code
sleep detl.
applies:
Y or N

Comments:

Summary of Service Types		Personal Support				TRV	Total Hours
Summary of Hours per Service Type							

Total OVT Hrs.

*FOR OFFICE USE ONLY

I certify, that this is an accurate record of the services I have provided.

Employee Signature: _____ Date: _____
*required

I certify, that this is an accurate record of the services this employee has provided.

Employers Signature: _____ Date: _____
Employer Phone #: _____ *required

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