ORION ISO, INC

Personal Supports

Consumer Name: ______________________

Employee Name: ______________________

Month: ____________ Due Date: 17th 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 dedt. 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:____ Date:______________
*required

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

Payroll Contact:
763-450-5191

ORION ISO, INC

Personal Supports

Consumer Name: ______________________

Employee Name: ______________________

Month: __________ Due Date: 2nd 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 dedt. 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

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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

ORION ISO, INC

Personal Supports

Consumer Name: ______________________

Employee Name: ______________________

Month: *Month of hours reports* — Due Date: 17th 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*	*RESP code sleep dedt. applies: Y or N*
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												

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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