

CNA/HHA CAREGIVER INVOICE

Client Name: _____

Independent Contractor CNA/HHA Name: _____

	MON	TUE	WED	THUR	FRI	SAT	SUN
Dates							
ADLs							
Bathing							
Continence							
Dressing							
Eating							
Toileting							
Transferring							
Other							
Med Reminder							
Assist With Medications							
Time-In							
Time-Out							
Less: Any Unpaid Time							
Total							
SUBMIT INVOICES ONLINE AT WWW.FLORIDABESTHOMECARE.COM/CARE-TIME					Total Hours		
<i>CNA/HHA Signature (required)</i>						<i>Date</i>	
<i>Client Signature (required)</i>						<i>Date</i>	

By signing above, I hereby acknowledge and affirm that the hours listed above in this Invoice are accurate and reflect the actual number of hours I worked for the identified Client during the days listed. The hours have not been rounded, estimated, or templated, but are the exact times I started my work and ended my work. The hours have not been altered or falsified. I acknowledge and affirm that the information contained in this Invoice represents all the time I worked for the identified Client during the days listed and that these reported hours do not underreport the hours I worked in any way. As an independent contractor, I understand it is my responsibility to accurately record and bill for the hours I work. I understand that falsifying or providing inaccurate information in this Invoice may result in the Client terminating my services. I hereby certify that no one has coerced, unduly influenced, encouraged, or intimidated me into providing inaccurate information in this Invoice.