ATTENDANT CARE FORM
[Return completed form to Risk Management, PO Box 8020, Tallahassee, FL 32314]

RE: _____ SSN: _____ D/A: _____

DATE	SERVICES PROVIDED	# HOURS/DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	TOTAL HOURS CLAIMED:	_____

ATTENDANT'S SIGNATURE: _____

ATTENDANT'S NAME: _____

ATTENDANT'S SOCIAL SECURITY NUMBER : _____

ATTENDANT'S ADDRESS: _____

_____**(PHONE):** _____

*****Hourly Wage Claimed: $_____.___ (Note: Unemployed family members are paid at minimum wage: Employed family members who miss work to provide attendant care are paid an hourly rate equal to their employment or the average rate for attendant care in the area: Professional attendants are paid the actual charge not to exceed $12.50 per hour without prior authorization.)**