**Disability Development Resources, L.L.C.**
**Fax #480-247-4756**
**Meeting Attendance[*1] Billing Document**

Direct Support Professional Name:_____ Direct Support Professional ID#:_____

MEETING ATTENDANCE MUST BE REQUESTED BY DDR, OR OTHERWISE PRE-APPROVED IN ORDER TO BE BILLED

| **Date** | **Consumer** | **Type of meeting**[*2] | **Time In (am/pm)** | **Time Out (am/pm)** | **Hours worked** | **Meeting Attendance Validation** (to be signed ONLY by Director or Consumer/Responsible Party when Director is not available) |
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| | | | | | Total hrs. | |

[*1] Meeting attendance criteria is defined as hours outside of your RSP, HAH or ATC service delivery hours.
[*2] Interview (this pay will be limited to 30 minutes), ISP, IEP (special education), Behavior Plan, Emergency, Other (please specify)

_____ _____
Direct Support Professional Signature Date Director Approval Date

**FOR PAYROLL USE ONLY**

| DSP payroll processed |
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HCBS005 03/08