CLIENT BILLING SHEET
SHP PROGRAM

CONTRACTING ORGANIZATION: _____

Staff Person's Name: _____ For the Pay Period: _____

DATE OF SERVICE	CLIENT NAME (OR IDENTIFIER)	APPROVED LINE ITEM	HOURLY RATE $	TIME SPENT WITH CLIENT (hours, in ¼ hour increments)	TOTAL COST FOR SERVICES
EXAMPLE	ABC123	CASE MNGMT	32.75	5.25	**$171.94**
EXAMPLE	ABC123	JOB TRAINING	15.50	3.75	**$58.13**
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CERTIFICATION:
I certify that the information on this Client Billing Sheet is a true and correct record of time worked with the person or family indicated under Client Name. I also certify that the person indicated is eligible under 24 CFR 583, and other applicable federal standards. I certify that these service items were approved in our grant application and technical submission.

_____ _____

Staff Person Signature Date Supervisors Signature Date