

# INVOICE

[Respite Care Provider Name]  
[Business Address]  
[Phone Number]

INVOICE # [0000]  
DATE: [Date]

**BILL TO:**

[Client/Guardian Name]  
[Address]  
[City, State, Zip]

**CARE FOR:**

[Senior's Full Name]

Service Date(s)	Description of Care	Hours/Days	Rate	Total
[Date Range]	In-home Respite Care	[Qty]	\$0.00	\$0.00
[Date Range]	Overnight Support	[Qty]	\$0.00	\$0.00

**Subtotal: \$0.00**

**Tax: \$0.00**

**Amount Due: \$0.00**

---

**PAYMENT TERMS:** Due within [X] days of invoice date.

**NOTES:** Thank you for allowing us to care for your family member.