



## Paperwork Turn-In Instructions

**Providers, please assemble your paperwork in the following order before turning it in to your field supervisor.**

### **Pile 1:**

- Original "Employee Monthly Billing Document"
- Copies of each clients "Individual Client Billing Document"
- \* All stapled together

### **Pile 2:**

- Copy of "Employee Monthly Billing Document"

### **Pile 3:**

- Copies of client's Habilitation Data/Summary Sheets, and/or "Attendant Care Checklist."
- \* Each client separately stapled together.

### **Pile 4:**

Originals:

- \* Separate by client, each clients paperwork stapled together.
- "Individual Client Billing Document"
- Habilitation Data/Summary Sheets and/or "Attendant Care Checklist."
- "Daily Notes"

# Visual Paperwork Turn-In Instructions

Providers, please assemble your paperwork in the following order before turning it in to your field supervisor.

## Pile 1:

Garbrie Management Services LLC  
Employee Monthly Billing Document

Provider Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Pay Period: \_\_\_\_\_ of \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Client Name (Alphabetical order): \_\_\_\_\_ Attention: \_\_\_\_\_ Habilitation: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Provider Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_  
*The above form is to be reviewed and approved by payment due for each period indicated. Undersigned no longer in any part may result in loss of funds.*

Garbrie Management Services LLC  
Employee Monthly Billing Document

Provider Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Pay Period: \_\_\_\_\_ of \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Client Name (Alphabetical order): \_\_\_\_\_ Attention: \_\_\_\_\_ Habilitation: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Provider Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_  
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(Alphabetical order)

## Pile 2:

Garbrie Management Services LLC  
Employee Monthly Billing Document

Provider Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Pay Period: \_\_\_\_\_ of \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Client Name (Alphabetical order): \_\_\_\_\_ Attention: \_\_\_\_\_ Habilitation: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Provider Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_  
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## Pile 3: \*Staple separately by client

Garbrie Management Services LLC  
Attendance Care Checklist

Client Name: \_\_\_\_\_ Attention: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Provider Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_  
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Garbrie Management Services LLC  
Attendance Care Checklist

Client Name: \_\_\_\_\_ Attention: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Provider Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_  
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## Pile 4: \*Staple separately by client

Garbrie Management Services LLC  
Employee Monthly Billing Document

Provider Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Pay Period: \_\_\_\_\_ of \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Client Name (Alphabetical order): \_\_\_\_\_ Attention: \_\_\_\_\_ Habilitation: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Provider Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_  
*The above form is to be reviewed and approved by payment due for each period indicated. Undersigned no longer in any part may result in loss of funds.*

Garbrie Management Services LLC  
Employee Monthly Billing Document

Provider Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Pay Period: \_\_\_\_\_ of \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Client Name (Alphabetical order): \_\_\_\_\_ Attention: \_\_\_\_\_ Habilitation: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
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Attendance Care Checklist

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
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Attendance Care Checklist

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
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