



SUPPORT STAFF ASSISTANCE

DATE: _____

Support Staff Provider Name _____
First (please print legibly) Last

Mailing Address: _____
Street or PO Box

City State Zip Code

Day-time Phone #: () _____
Area Code

Social Security #: _____

Support Staff Assistance is paid at a rate of *\$12.00/hr, OR *\$96.00/day (8 hours max.)

I, _____, on _____
Support Staff Provider Name month / day / year

provided personal assistance care for _____
Name of Person Cared for

for the number of hours or full day indicated below

Please check one:

[] _____ hours [] full day (eight hours/day max.)
of hours

Total Amount Due: \$ _____

NAME OF PERSON ATTENDING TRAINING:

FIRST NAME

LAST NAME

I certify that the above information is true and accurate. _____
Support Staff Provider Signature Date

***SUBJECT TO CHANGE**
Please mail completed form for payment to:
UDDC Administrative Secretary
155 South 300 West, Suite 100
Salt Lake City UT 84101
Phone: (801) 533-3965
Fax: (801) 533-3968

Approved by: _____

Date: _____