

FROM

Your business name
Address
Phone · email

BILL TO

Client name
Client address
Phone · email

ESTIMATE #	DATE	VALID UNTIL
CARE RECIPIENT	SERVICE PERIOD	LTC POLICY # / CLAIM #
CAREGIVER / CREDENTIALS		

DESCRIPTION	QTY × RATE	AMOUNT
Shift: date, start–end, type of care (hours × day rate)		
Shift: date, start–end (hours × night / weekend rate)		
Overnight: sleeping / awake (flat or hourly)		
Holiday shift (rate × multiplier)		
Mileage / errands / supplies (receipts)		
Other		

NOTES & PAYMENT TERMS
This estimate is valid for 30 days. Final invoice may vary if the scope changes; any change will be approved in writing before work continues. Deposit of 30% due on acceptance.

Subtotal
Tax
ESTIMATED TOTAL