REQUEST FOR PAYMENT FOR RESPITE CARE SERVICES

Provider Identification **Please Print**	Office use Only
Name:	
Address:	
City: State ZIP	
S.S.N. #	

FAMILY AUTHORIZATION NUMBER:_____

Family Information		Respite Care Service Information			
No	**Name of Child or Adult**	**Date of Service**	**# of Hours**	**Hourly Wage**	**Total Amount**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

TOTAL

The above listed Respite Care was not used as child or adult day care while the family member was at work.
I declare and affirm under the penalties of perjury that this claim has been examined by me and to the best of my knowledge and belief is in all things true and correct. I further agree to comply with the provisions of the Civil Rights Act of 1964 and regulations issued thereunder relating to non-discrimination in Federally assisted programs.

_____ _____
Provider Signature Date Family Signature Date

_____ _____
Print Name Print Name