DEPARTMENT OF HUMAN SERVICES

Respite Care Reimbursement Receipt of Payment

All reimbursement requests must be postmarked by the fifth of each month. Complete a **separate reimbursement request for each child and/or respite care provider.** Each reimbursement request **MUST** be completed in its entirety. All incomplete reimbursement requests will be returned which may result in delay of reimbursement.

To be completed by parent:

Child's full legal name: ____

Child's date of birth:____

Parents' names: ______________________ and _____________________________

Street address: ____

City, state, and zip: ____

Phone number:____

E-mail address: ____

To be completed by the respite care provider:

Provider's name: ____

Provider's address: ____

City, state, and zip: ____

Provider's phone number: ____

Provider's relationship to child ____

Dates of service: (i.e., from Jan. 1, 2010 to Jan. 31, 2010) From_______ To________

Total number of units: (i.e., 10 hours or 2 days) ________ Hour(s) or _________ Day(s)

Total amount paid to respite care provider: $_________________________________

Date payment was made to respite care provider: (xx/xx/xxxx) _____________________

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Read Carefully
By signing this form you certify that all expenses for which reimbursement of payment is claimed by submission of this form, you fully understand that you alone are responsible for the sufficiency, accuracy, and veracity of all information relating to this claim.

By signing this form you understand that, in order to prevent fraud, you may be audited by the Adoption Assistance program. You will need to save your receipts for expenses you are requesting reimbursement for. If a receipt or documentation is needed you will receive notification from the Adoption Assistance program. If a receipt is not provided you may be subject to re-payment of the funds.

____________________________________ ________________________

Parent signature: (only one parent must sign) Date signed: