Family Reimbursed Respite

Month/Year of Service:_____

Participant Name: _____

Check Payable to (include full name and address):_____

_____

***Check can only be paid out to the Designee/Parent – Designee/Parent is responsible for paying the person that provides the respite service. This is only to reimburse for expenses from Family Reimbursed Respite.

Date	Time In	Time Out	Total Hours Worked	Hourly Rate	Amount Paid

****Signing and submitting false information, may lead to a Medicaid fraud charge****	**Total Amount Paid:** **$_____**

_____ _____

(Signature of Individual/Designee) (Date)

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