Respite Care Program Payment Request

Name of Resource Parent		
Address		
Phone Numbers	Cell:	Email:

RESPITE CARE PROVIDER INFORMATION (1099 will be issued for amounts greater than $600)

Name		Relationship to Resource Parent	
Address			
Phone Number	Cell:	Email:	
Respite provider is	☐ County RFA Home ☐ Approved RFA Respite Provider ☐ Daycare Facility ☐ FFA - Approved Resource Home (prior approval must be obtained from FFA Social Worker)		

There are 300 hours allowable for Respite Care per fiscal year.
For overnight stays, 10pm – 6am are non-payable hours
Forms MUST be submitted no later than 15 days after the respite has occurred.

Name of Child	Age	Foster	Adopt	Guard	Birth	Start Date	Start Time	End Date	End Time	Total Hours
		☐	☐	☐	☐					
		☐	☐	☐	☐					
		☐	☐	☐	☐					
		☐	☐	☐	☐					
		☐	☐	☐	☐					
		☐	☐	☐	☐					

Reason for Respite	

Reimbursement Chart

1 child	2 children	3 children	4 children	5 children	6 children
$24.56/hr.	$31.56/hr.	$38.56/hr.	$45.56/hr.	$52.56/hr.	$59.56/hr.

Total payable Respite Hours		Amount per hour $	**X**	hours = $	
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT, INCLUDING THAT I HAVE LEFT MY CHILD/REN IN RESPITE CARE FOR THE ABOVE MENTIONED DAYS AND TIMES.					
Resource Parent Signature				Date	
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT, INCLUDING I HAVE PROVIDED RESPITE CARE FOR THE ABOVE MENTIONED CHILD/REN ON THE DAYS AND TIMES.					
I am able to provide a ☐ Social Security Number ☐ Tax ID number as required by the County to receive payment for the respite. I understand that without either document, I will not receive payment.					
Respite Care Provider's Signature				Date	

FOR INTERNAL USE ONLY

Respite care Program Reimbursement Request Form received: Date: _____

Received by: ☐ Mail ☐ Email ☐ Drop Off

If respite care is over 24 hours, was the provider verified through the Respite Care Coordinator?

____ Yes _____No

Total of respite hours remaining as of this request: _____

Approved _____ Amount $ _____ Denied _____ Reason: _____ _____		Date	
Respite Care Coordinator's Signature		Date	