

COMMISSIONER'S RESPITE CARE REIMBURSEMENT REQUEST

Name of Resource Family _____

Date of Care _____

Address _____

of Hours of Care _____

Provider # _____

of Foster Children Using

Respite _____

NAME OF CHILD _____

REASON FOR CHILD CARE:

I have previously used the State Respite Funds this month _____

Case Meeting/Conference _____

SOURCE OF CHILD CARE:

Child Health Care Appointment _____

Babysitter in Our Home _____

Provider Training _____

Day Care Home/Center _____

Support Group _____

Other Resource Family _____

Time Away _____

Other _____

Family Emergency _____

Other _____

Respite Money Received By _____
(Name of Respite Care Provider)

Provider Requesting Reimbursement _____ Amount Paid \$ _____
(Signature)

Reimbursement Approved By _____ / _____
(Resource Family Team [R.F.T.] Worker) (Resource Family Team [R.F.T.] Supervisor)

- Form must be submitted to R.F.T. worker by the 5th of the month.
- Please fill out entire form.

NO BILLS WILL BE PAID IF SUBMITTED OVER 45 DAYS FROM THE DATE OF CARE.

Copies: *White* – Accounting *Canary* – R.F.T. Worker *Pink* – Child Protection Worker
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