

## Respite Care Reimbursement Request

### Completed by Family : Must Sign Below

Amount Claimed: \$		
Name: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Phone: _____		
Services for: _____ Name of Family Member(s)		

### Completed by Respite Care Provider/Volunteer : Must Sign Below

Name: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Phone: _____		
Location : _____		
# of Volunteer Hrs: _____	Date of Care: _____	
In: _____	Out: _____	
# of Paid Hours: _____	Date of Care: _____	
Rate of Pay: \$ _____	In: _____	
In: _____	Out: _____	

#### **Family/Caregiver**

I have received Respite Services as indicated above. I understand that it is my responsibility to compensate the providers for their services.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

#### **Respite Provider/Volunteer**

I have provided respite services at the time/date specified above.

\_\_\_\_\_  
Signature of Respite Provider

**Mail this completed form to: Dodge County Lifespan Respite Network  
Offices located at FYICS  
211 Corporate Drive, Suite F  
Beaver Dam, WI 53916**

Reimbursement forms must be received by the DCLRN office no later than two weeks after the respite has been provided.

Checks will be cut on the 1st and 15th of each month and in most cases will be sent within one month of receiving the completed request form.

If you have questions, please call (920) 356-9870.