

Respite Care Reimbursement Request

Completed by Family : Must Sign Below

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

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: \$ _____	Out: _____	
In: _____		

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 FYI ZONE
1645 North Spring Street
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.