

FAMILY REIMBURSEMENT REQUEST VOUCHER

VOUCHER MUST BE RECEIVED BY 3PM ON WEDNESDAY FOR REIMBURSEMENT TO BE MAILED THE SAME WEEK
Voucher must be received within 90 days of service for reimbursement to occur

Respite Support for _____
 (Name of individual receiving support) (Parent or Guardian's Signature)

Parent or Guardian Pay To:

OS reimburses parents/guardians directly. Parents/guardians are responsible for paying their providers.
Please fill in a parent/guardian name ONLY.

Name: _____
 Street: _____
 Town: _____ State: _____ Zip Code: _____
 Telephone #: _____ Date Submitted: _____

Check here if this is a change of address or phone Check here if more forms are needed

ATTENTION

It is important that the information reported on this form is *extremely accurate*. Respite reimbursements are paid out of State and/or Federal funds; vouchers may be subject to Medicaid audits. Only list dates and times that you actually paid someone to provide support.

Hourly Rate to Provider _____ Family Contribution-Hourly _____ One Sky Hourly Share _____

Date Respite Provided	Time Respite Began	Time Respite Ended	Total # of Hours	OS Hr/Day Rate	Amount Reimb to Family	PRINT FULL NAME OF PROVIDER Voucher will be returned if this section is not completed.

Total Reimbursed to Family

- 1) Are you satisfied with the Respite Program and its ability to meet your needs? _____ Yes _____ No If no, please explain: _____
- 2) Would you like the Respite Coordinator to call you? _____ Yes
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Respite Coordinator Signature: _____

Business office use: Code _____ Check # _____ Date _____