**RESPITE CARE REIMBURSEMENT REQUEST**

Print Recipient Name: ________________________________

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<tr>
<th>Date (one day per line)</th>
<th>Start (AM or PM)</th>
<th>End (AM or PM)</th>
<th>Hours</th>
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Rate of pay: $ _____ X Total hours: ______ = **REIMBURSE** $ ____________

**Respite Recipient**
By signing this form I am stating that my respite worker performed the necessary tasks to my satisfaction on the date(s) and/or time(s) indicated above. I understand that it is my responsibility to compensate the providers for their services.

______________________________
Print name (Parent / Guardian)

______________________________
Signature (Parent / Guardian)

I need more forms: ( ) Yes ( ) No

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

______________________________
Print name (Respite Provider)

______________________________
Signature (Respite Provider)

______________________________
Print name (Respite Provider)

______________________________
Signature (Respite Provider)

______________________________
Print name (Respite Provider)

______________________________
Signature (Respite Provider)

I need more forms: ( ) Yes ( ) No

Phone: 414-329-4500 ♦ Fax: 414-329-4510 ♦ Text: 262-373-9870

Mail promptly to:
** Broadscope - RESPITE CARE PROGRAM **
6102 W Layton Ave, Greenfield WI 53220

Forms must be in office on Mondays before 2:00 p.m. in order to be processed for that week.
Reimbursement forms should be mailed to the Broadscope office no later than one week after the Respite period.
Checks will be mailed to the Parent/Guardian.