RESPITE PROVIDER SERVICES & ASSOCIATED MILEAGE REIMBURSEMENT

Invoice# (optional)_____

NAME: _____

ADDRESS _____ PROVIDER'S SOCIAL SECURITY NO: _____

_____

Signature: _____

(social and signiture are required for payment)

DATE OF RESPITE	FAMILY/ CHILD NUMBER	NAME OF CHILD	START TIME	END TIME	TOTAL PAYMENT AMOUNT	MILEAGE DETAIL (EX.WATERBURY - BARRE & RETURN)	NUMBER OF MILES
						Total number of Miles	0.00
						Mileage Rate:	
			Total Dollar Amount for Respite		$ 0.00	Total Amount for Mileage	$ 0.00
						Grand Total	$ 0.00

Respite care must be pre-approved. Two methods of reimbursement are acceptable.

1. Foster parent has paid the provider, foster parent will fill out this form and attach a receipt from the provider .

(example: I Mary Doe provided respite care for Joey Smith on 1/3/2017. I received $20.00 from Sally Smith for this service.

2. Provider can bill DCF directly for services. (note by billing directly you are stating you have not been paid by any other source.)

DISTRICT OFFICE USE ONLY:

LICENSED FOSTER PARENT: YES ☐ NO ☐

CHILD INFORMATION:
- IN CUSTODY (USE RESPITE CODE BELOW) ☐
- OPEN FAMILY CASE (USE RESPITE CODE BELOW) ☐
- NO OPEN CASE (USE FAMILY PRES CODE BELOW) ☐

BUSINESS OFFICE USE ONLY:

APPROVAL SIGNATURE: _____ Date: _____

Dept ID _____ Account Code: 603230(TRANSPORTATION)

Program Code: 603110 (RESPITE) 603060/603061 (FAMILY PRES)