

Respite Provider Name:	
Respite Provider Signature:	
Respite Provider Phone #:	
Services Provided to (Child's Name):	

Date(s) of Service (MM/DD/YYYY)	Start Time	End Time	# of Hours	Rate charged (per hour)	Amount Invoiced

<b>Total Hours</b> of Sessions/Services:	
<b>Total Invoice:</b>	

<b>Name of Parent or Guardian</b> (please print):	
<b>Signature</b> of Parent or Guardian:	
<b>Date Signed:</b>	

**PLEASE NOTE:**

Provider **must** be 18 years of age or older.

Claim is to be filed under "**Lifestyle**".

One invoice can be submitted monthly if the same provider provides respite services multiple times in the same month.