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| --- | --- |
| 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** |
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| --- | --- |
| **Total Hours** of Sessions/Services: |  |
| **Total Invoice:** |  |

|  |  |
| --- | --- |
| **Name of Parent or Guardian** (please print): |  |
| **Signature** of Parent or Guardian: |  |
| **Date Signed**: |  |

**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.*