



Family Directed Respite Payment Request

Requests are due every other Friday by 5pm (see payment schedule for dates)

Late requests may not be paid (need director approval)

Checks are ready the following Friday after 1:00pm

Consumer /Child's Name: _____

Parent Initials	Date	Time From - To (include AM or PM)	Total Hours (use decimals in quarter hour increments)	Hourly Rate (1-12 Hours) See #1 below	Daily Rate (12- 24 Hours) See #1 below	Total \$ (total hours x hourly rate) or (flat daily rate)
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		-				
		Total Hours:			Amount Due:	\$

By submitting a request you agree to the following:

- Hourly rate of pay of \$10 for 1-12 hrs (\$15/2 consumers), daily rate of \$150 a day for 12-24 hours (\$225/2 consumers).
- FDS staff may correct and adjust the hours or pay as needed to comply with program guidelines.
- Requests must be submitted during the month services occurred (or by end of next month).
- Parent must initial each day of respite on this page, and put full signature on second page of this request.
- Provider must fill in form completely; including daytime phone # you can be reached at.

Make sure to complete the back of this form

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Requests may be submitted by mail to the above address, by fax, at the CSS office M-F 9-5pm, or in the FDS after hours drop box next to the main entrance of CSS. Requests received over the weekend will be accepted; all requests received past 8 am Monday may be processed during the next pay period. Please call the FDS Program Coordinator at 222-7325 with any questions.

No monies will be paid out without proper documentation of activities. Please fill in the following information by briefly describing what activities took place, how you helped with grooming or meals, and any concerns.

Date	Grooming/ Hygiene	Meals/ Snacks	Activities/outings/concerns or problems

Please check:

Pick up check (checks not picked up by Mon. will be mailed)
 Mail check
 Change of Address

Provider Signature

Printed Name

Address

Address cont.

Provider Phone Number

Vendor Number

Parent Signature

By signing this request I agree to the terms & conditions of the Family Directed Respite Agreement (see terms and conditions).

For Office use only:

Fund	Prog	Gl Acct	Sub - 2	Grant	Amount	Notes
A__	--	----	----	----	-----	_____
A__	--	----	----	----	-----	_____
Total Amount					-----	
Authorized by _____				Date ____/____/____		