

Family Reimbursed Respite

For the Month of: _____

****Sample****

Participant Name: _____
 (Please Print)

****Sample****

Check Payable to: _____
 (Please Print - ** Family ONLY**)

Date of Expense (MM/DD/YY)	Time In (AM/PM)	Time Out (AM/PM)	Total Hours	Hourly Rate	Amount Paid
			}		
Sample					
IMPORTANT NOTES					
Date, Time and Amount are required on all Requests including those where a Flat Rate is paid for multiple days.					
(see Weekend Example)					
Sample					
					Total to be reimbursed:

I certify that the above hours of Respite Services were provided for the Participant noted above.

****Mary Jones****

 Signature of Designee (Required)

****Sample****

 Date (MM/DD/YY)

Signing and submitting false information may lead to a charge of Medicaid fraud

Remit to: P.O. Box 1320, Monticello, NY 12701

Rev 5/31/18