ISS INDEPENDENT SUPPORT SERVICES INC.
Make your Own Path

Family Reimbursed Respite

For the Month of: January 20xx

Participant Name: **Owen Ellis** **Sample**
(Please Print)

Check Payable to: **Maxine Ellis** **Sample**
(Please Print - ** Family ONLY**)

Date of Expense (MM/DD/YY)	Time In (AM/PM)	Time Out (AM/PM)	Total Hours	Hourly Rate	Amount Paid
1/2/20xx	2 pm	4 pm	2	10	20
1/4/xx	2:00 pm	4:00 pm	} 8	week-	
1/5/xx	2:30 pm	5:30 pm		end	100
Jan 6	10 am	1:00 pm		rate	

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: 120

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

Maxine Ellis **Sample** 1/28/20xx

Signature of Designee (Required) **Maxine Ellis** 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