ISS INDEPENDENT SUPPORT SERVICES INC.
Make your Own Path

Family Reimbursed Respite

For the Month of: _____

Participant Name: _____
(Please Print)

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**

Total to be reimbursed: 0

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

_____ _____
Signature of Designee (Required) 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