

RESPITE CARE ALLOWANCE REQUEST

Instructions: A maximum of \$75 each quarter per family will be reimbursed for the cost of respite. Payment to the respite provider must be supported by a signed and dated receipt, check stubs, or signature of the respite provider below. **Please submit allowance request one time each quarter.**

This is a request for respite care allowance covering the period (check one):

Jan-Feb-March (Due by April 10th) April-May-June (Due by July 10th)
 July-Aug-Sept (Due by October 10th) Oct.-Nov.-Dec. (Due by January 10th)

Youth(s) Name	Dates of Respite	Amount Paid

Respite Provider Signature

I, _____, respite provider, verify that I was paid
 \$_____ to provide respite for the identified youth on the dates stated above.
 Signature: _____ Date: _____

I, _____, respite provider, verify that I was paid
 \$_____ to provide respite for the identified youth on the dates stated above.
 Signature: _____ Date: _____

Foster Parent Name (print): _____

Foster Parent Signature: _____

Date Submitted: _____