

# RESPITE CARE REIMBURSEMENT REQUEST

Print Child / Adult Name: \_\_\_\_\_

Date (one day per line)	Start (AM or PM)	End (AM or PM)	Hours
1.			
2.			
3.			
4.			
5.			
Total Hours:			
Rate of Pay	____ X	____ Hours →	\$
Co-Payment Rate	____ X	____ Hours →	- \$
<b>REIMBURSE</b>			<b>= \$</b>

**Respite Recipient**

I have received Respite Services as indicated above. I understand that it is my responsibility to compensate the providers for their services.

\_\_\_\_\_  
Print name (Parent / Guardian)

\_\_\_\_\_  
(Signature of Parent/Guardian)

I need more Forms  
( ) Yes ( ) No

**Respite Provider**

I have provided respite services at the time/date specified above.

\_\_\_\_\_  
(Signature of Respite Provider)

**\*Reimbursement forms must be mailed to the UCP office no later than one week after the Respite period. Forms must be in office on Monday's before 2:00 p.m. in order to be processed for that week. Checks will be mailed to the Parent/Guardian.**

**Fax Number: 414 / 329-4510**

Mail Promptly to:  
**\*\* UCP - RESPITE CARE PROGRAM \*\***  
7519 W Oklahoma Ave., Milwaukee, WI 53219

\*\*\*\*\* FOR OFFICE USE ONLY \*\*\*\*\*

Pay to: \_\_\_\_\_

Quarter: 1 ( ) 2 ( ) 3 ( ) 4 ( )

Total # Hours: \_\_\_\_\_

Quarterly Allowance \_\_\_\_\_

Total Amount \$ \_\_\_\_\_

Hours used \_\_\_\_\_

Approved by: \_\_\_\_\_

Hours remaining \_\_\_\_\_

Dept.

Category: A ( ) B ( ) C ( )