

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 →	- \$
REIMBURSE			= \$

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 ()