

DELAWARE LIFESPAN RESPITE NETWORK INVOICE FOR SERVICES PROVIDED

FOR DLRCN USE ONLY	
Application number: _____	
Month/Year Submitted: _____	
Total Hours: _____	
Funds Remaining: _____	
Approved: _____	61400-300-418-212

Make extra copies of blank invoices to keep on hand. Invoice must be signed by the caregiver and the provider after care is completed. Make three copies of completed invoice: mail/hand-deliver one copy to the **Delaware Lifespan Respite Network** program, caregiver keeps one copy, and provider keeps one copy. For care that takes place toward the end of the year, you must submit invoices no later than **October 15th, 2012**.

****Important: Please print clearly. If information is not readable, it may result in delay of payment.****

Information about you and the care recipient(s)	Please fill in all information requested
Caregiver Name	
Caregiver Daytime Telephone #	
Dates of Care	
Hours of Care	
1 st Care Recipient's Name and Age	
2 nd Care Recipient's Name and Age	
Full Cost of Care	\$
Amount to Be Paid*	\$

Information about the respite care provider	Please fill in all information requested
Provider Name	
Type of Care (check one)	<input type="checkbox"/> Facility/center <input type="checkbox"/> Family child care business <input type="checkbox"/> In-home agency <input type="checkbox"/> Family member or friend <input type="checkbox"/> Other: _____
Provider Telephone #	
Social Security # or EIN	

Caregiver: I hereby certify that the information listed on this invoice is correct, and that the use of this care is respite-related and short-term. I also certify that this provider meets the following requirements:

- is 19 years of age or older
- has provided a Social Security # or EIN
- is not my spouse/partner or the care recipient's parent
- is not the care recipient's regular care provider, unless being used for additional hours beyond the normal care schedule

I accept responsibility for payment of services rendered if they are not covered by my **Delaware Lifespan Respite Network** account.

Caregiver Signature _____

**Amount to be paid is based on award amount, amount of money remaining in caregiver's account, and any other guidelines set by the Delaware Lifespan Respite Network.*

Provider: I certify that I provided care to the person(s) listed for the hours shown. In signing this invoice, I certify that I meet the **Delaware Lifespan Respite Network** requirements (see bottom of first column), and that the information given by me is correct.

Provider Signature _____

Note to caregiver: If the provider is a friend, relative, or independent contractor, the payment must be sent to you as reimbursement. If you use a licensed home health agency, licensed PASA, respite program, adult day program, or assisted living facility, you can either 1) pay the provider and have the payment sent to you as reimbursement, or 2) have the payment sent directly to the provider. If you choose Option 2, please include a copy of the provider's invoice along with this Invoice Form. Below, indicate whether the check is to be sent to you or to the provider.

Send payment to me Send payment to provider

Make check payable to:	
Street address:	
City:	
State:	Zip:
___ check here if this is a new address	

By participating in the Delaware Lifespan Respite Network program, the caregiver and respite care provider agree that the Delaware Lifespan Respite Network will not have any liability, direct or indirect, for the actions of any particular provider or any adverse consequences that may arise in connection with the use of the Delaware Lifespan Respite Network program.

**Mail or hand-deliver voucher to:
Delaware Lifespan Respite Care Network
61 Corporate Circle, New Castle DE 19720-2439
302-324-4444**