Respite Voucher Reimbursement Form

Return Voucher to: DEAP * 2200 Box Elder * Miles City, MT 59301 * ATTN: Vicki Clear

Care Recipient Name ____________________ **Primary Caregiver Name** ____________________

Date of Respite	Time In	Time Out	# Hours	Rate of Pay	Total Paid	Respite Provider Signature

Caregiver respite time was used for ____________________

Date of Respite	Time In	Time Out	# Hours	Rate of Pay	Total Paid	Respite Provider Signature

Caregiver respite time was used for ____________________

Date of Respite	Time In	Time Out	# Hours	Rate of Pay	Total Paid	Respite Provider Signature

Caregiver respite time was used for ____________________

Date of Respite	Time In	Time Out	# Hours	Rate of Pay	Total Paid	Respite Provider Signature

Caregiver respite time was used for ____________________

I certify that all information stated on this voucher is true and I am submitting it for reimbursement minus my cost-share amount.

____________________ Signature of Primary Caregiver

____________________ Date

For Office Use Only

Voucher # ___________________________	Total This Voucher _________________________	Processed by ____________________________
Amount Used to Date ___________________	Amount Remaining ________________________	Date Entered _______________________________