~ Virginia Lifespan Respite Voucher Program ~

Reimbursement Form

Reimbursement Process: The maximum amount of funding for a voucher through the *Virginia Lifespan Respite Voucher Program* is $400 per family, and only one ***Application Form*** may be submitted per family. All voucher funds must be expended no later than July 31, 2013. Once you have been notified that your ***Application Form*** for a funding voucher has been approved, and for what amount, you may go ahead and arrange for respite services through an individual provider or respite program. Ideally, you will submit a ***Reimbursement Form*** immediately after the respite services have been provided for the Respite Care Recipient, but no later than thirty (30) days after the purchase and delivery of the respite services. Note that we will be unable to honor any requests for reimbursement that are submitted 90 days after the provision of respite care services, or after the July 31, 2013 deadline.

This ***Reimbursement Form*** is only to be used for reimbursement of pre-approved respite care expenses through the *Virginia Lifespan Respite Voucher Program.* You should request reimbursement only for the actual amount of funding used! If you did not expend all of the funding for which you were originally approved due to a change in plans, let us know as soon as possible if you will use any of the remaining funds for respite services prior to the July 31, 2013 deadline. If you were approved for respite care services that occur more than 30 days apart, you may submit a separate ***Reimbursement Form*** for each request. We can provide you with multiple copies of this ***Reimbursement Form*** or you can download the form from the DARS website at http://www.vadars.org.

How to Apply for Reimbursement: The person applying for funding through the *Virginia Lifespan Respite Voucher Program* must be the Primary Family Caregiver and must live in the same household as the Respite Care Recipient. The Primary Family Caregiver is required to sign the form and is responsible for the appropriate use of funds received through this program. In addition, the respite care services provider must sign this form to certify that the date(s) and number of hours of respite care services were provided as described in this ***Reimbursement Form***. If this form is not signed by the person who provided the respite care services, we cannot process a payment reimbursement for you. Please provide the information below:

____

Primary Family Caregiver (***the person who applies for funding for respite services***)

____

Respite Care Recipient (***the person who receives respite services***)

____

Physical Address/City/State/Zip (***where the Primary Family Caregiver and the Respite Care Recipient reside***)

________________________________/____

County of Residence/E-mail

_______________________/_______________________________/____________________

Home Phone/Cell Phone/Work Phone

Date(s) and number of hours that respite care services were provided: Date:______________/ ________hours; Date:______________/ ________hours; Date:______________/ ________hours

Total number of hours of respite care services provided: ___________________________Total hours

How much did the respite provider charge you per hour? $__________/hour

Total reimbursement amount due to you: $__________ (hourly charge x number of hours of services)

Reimbursement Voucher Claim Form

This pink section only to be filled out by the individual who provided the respite care services:
I certify that respite services were provided to the Respite Care Recipient on the dates, and at the hourly rate, described in this ***Reimbursement Form***.

Signature:____

Respite Care Provider	**Date**	**Phone / E-mail**

If respite care services were provided by an individual (and not through a respite care organization), I certify that this person meets the following requirements:

- ✓ Is 19 years of age or older
- ✓ Is not the spouse / partner of the Primary Family Caregiver
- ✓ Is not the parent of the Respite Care Recipient
- ✓ Does not reside in the Respite Care Recipient's home
- ✓ Is not the Respite Care Recipient's regular respite care provider, *unless* the funding was used for additional hours beyond the normal respite care provider's schedule.

I certify that the funds for which I am requesting reimbursement were used for short-term respite services for an individual living in my household and were provided by an individual respite care provider selected by me **or** through a respite provider organization. I accept responsibility for payment of any respite services rendered if they do not meet the requirements of the *Virginia Lifespan Respite Voucher Program* or if the amount is above the total funding that was pre-approved on my ***Application Form***.

By my signature below, I certify that the information I have provided on this *Virginia Lifespan Respite Voucher Program* ***Reimbursement Form*** is correct and accurate to the best of my knowledge.

____

Signature of Primary Family Caregiver	**Date**	**Phone / E-mail**

<u>Please make check payable to:</u>
Name: ____
Mailing Address: ____
Phone / E-mail: ____
***Social Security (SS) #** ____

**You may call 804.662.7154 or 800.552.5019 and provide your SSN# to Kristie Chamberlain over the phone if you prefer.*

Mail/Fax or Scan & Email this form to: Virginia Lifespan Respite Voucher Program, ATTN: Kristie Chamberlain, Virginia Department for Aging and Rehabilitative Services (DARS), 8004 Franklin Farms Drive, Henrico, Virginia 23229; or fax to 804/662-7663; Or e-mail to Kristie.Chamberlain@dars.virginia.gov.

*In order to receive reimbursement, the **Reimbursement Form** and the ***Virginia Lifespan Respite Satisfaction Survey*** must be submitted within 30 days of respite service receipt and delivery. *We will be unable to honor any requests for reimbursement that are submitted 90 days after the provision of respite care services, or after the July 31, 2013 deadline.*

Office Use Only (*please do not below)*

Date *Application Form* received:__________________________

Date *Application Form* approved: _________________________

Voucher number assigned: # ______________________________

Total voucher $ approved: ________________________________

Date *Reimbursement Form* received by DARS: _______________

Amount of $ requested in this *Reimbursement Form*: __________

Date request processed and sent to DARS Fiscal:_______________

Balance of voucher funding remaining:________________________