HALO NETWORK, INC
CENTER FOR EDUCATION AND ADVOCACY FOR INDEPENDENT LIVING
FAMILY REIMBURSEMENT AND RESPITE VERIFICATION FORM

- This form **must** be signed by the respite provider and the parent/family member where indicated to be eligible for reimbursement. **PLEASE COMPLETE ALL AREAS IN FULL FOR FORM TO BE ACCEPTED.**

PARTICIPANT: Name: ______________________ Date of Birth: _____________ Month of Service_________

PARENT/GUARDIAN: Name: ____Telephone__________________________

Address: ____

RESPITE PROVIDER: Name: ____Telephone__________________________

Address: ____

Date Service Provided (mm/dd/yyyy)	Time In	Time Out	Number of Hours	Rate Paid Per Hour	Total Amt. Paid Per Day

Total to be reimbursed (this page): $____________

I certify that I, ______________________ , provided the above hours of Respite Services and received a payment in the amount of $_______________ for the above services.

Respite Provider's Signature: ________________________________ Date __________________________________

Parent/Guardian Signature: ________________________________ Date __________________________________

Halo Network reserves the right to ask for proof of payment when deemed necessary.