

# Family Focus Respite Reimbursement Form

Please fill in all of the lines below and return the form to your social worker:

Foster Parents Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Information About the Foster Child(ren):**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

**Information About the Respite Provider:**

Name of Respite Care Provider: \_\_\_\_\_

Address of Respite Care Provider: \_\_\_\_\_

Home phone of Respite Care Provider: \_\_\_\_\_

Check one: Licensed foster parent ( ) Family Focus approved respite care provider ( )

Location of respite care: Foster parent's home ( ) Respite care provider's home ( )

**Payment Information:**

Date(s) of Respite Care – use a separate form for each month: \_\_\_\_\_

\_\_\_\_\_

Reimbursement amount: \_\_\_\_\_

This form must be signed by the Family Focus social worker. The reimbursement check will be sent to the foster parent(s). Reimbursement requests submitted *more than 45 days after the respite was provided* will not be paid.

\_\_\_\_\_  
Social Worker Signature

\_\_\_\_\_  
Date