SELF-DIRECTED SERVICES

FAMILY REIMBURSED RESPITE REQUEST

For the Month and Year of: _____

Participant Name (print): _____

Person Providing Respite (print): _____

Check Payable to (print, Family ONLY): _____

Date of Expense (MM/DD/YYYY)	Time IN (AM/PM)	Time OUT (AM/PM)	Total Hours	Hourly Rate	Amount Paid
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
				Total Reimbursement	0

I certify that the Provider of the Respite services documented above received payment at the time of service delivery. This request is for the reimbursement of my out of pocket expense per OPWDD Family Reimbursed Respite guidance. FRR is a reimbursement service to the family for the expense they incur in being relieved of their primary caregiver responsibilities. Springbrook is not paying the person that provides this relief and does not track or regulate whom they may be.

_____ _____

Signature of Designee (required) Date (MM/DD/YYYY)

_____ _____

Signature of Person Providing Respite (required) Date (MM/DD/YYYY)

Signing and submitting false information may lead to a charge of Medicaid fraud