Parent/Guardian, Please Mail Completed Form To:
The Arc of Durham County ● 3500 Westgate Dr., Suite 303 ● Durham, NC 27707
or fax form to 919-489-3434

Please note: This form is due <u>in our office</u> by the 1st working day of the month!

Family Voucher Respite Reimbursement Form

Please indicate to whom we mail the check:
Name _____
Address:_____
_____
Recipient's Name: _____
Phone Number: _____

☐ Check here to indicate that the address on the left is different from our records.

Office Use Only:
Date Rcvd: _____
Address Updated:_____

Date of Service	Respite Provider's Printed Name	Initials	Total Number of (Hours) (Days)	Rate Per Hour ( ) Per Day ( )	Amount Due

I will pick up my check____ OR
Please mail my check____

Amount Paid To Provider: _____

Requested Reimbursement: _____

The above is a true and accurate account of the respite services approved and provided. The parent/guardian and the respite provider understand that it is the responsibility of the parent/guardian to assure payment to the individual respite provider.

_____
Respite Provider Signature Date

_____
Respite Provider's Phone Number

_____
Parent/Guardian Signature Date

_____
Arc of Durham Date
Respite Care Director

<u>Comments or Questions? Call 493-8141 x203 for Karon or e-mail karonjohnson@verizon.net.</u>

For Office Use ONLY

Quarter	Amt. Reimbursed	Amt. Remaining for Quarter	Hours Billed to DCtr
☐ July 1 – Sept. 30 ☐ Oct. 1 – Dec. 31 ☐ Jan. 1 – March 31 ☐ April 1 – June 30	$	$	