Community Mental Health of Ottawa County
12265 James Street
Holland, MI 49424 **616-393-5657- FAX**

Respite Payment Request

Consumer Name	
Parent/Guardian	
Address City/Zip	
Telephone:	

LIST EACH DAY OF SERVICE/RATE/ HOURS AND WHERE RESPITE WAS PROVIDED PER DAY ON A SEPARATE LINE AND USE A SEPARATE VOUCHER FOR EACH PROVIDER

Note ***Maximum of $12 per hr/$150 per day** **NEW FISCAL YEAR STARTS OCTOBER 1ST**

DATE OF RESPITE SERVICES (mm/dd/yyyy)	**RATE PER HOUR or DAY**	**HOURS PER DAY**	**WHERE WAS RESPITE PROVIDED** (consumers home or providers home or in community?)	**AMOUNT DUE**	**PROVIDER INFORMATION (Please use black or blue ink)**
					Provider Name ***(please PRINT)***
					Street Address ***(please PRINT)***
					P.O. Box, Apt. Number, etc. ***(please PRINT)***
					City/State/Zip Code ***(please PRINT)***
					Telephone Number with area code ***(please PRINT)***
					Provider/Employee SIGNATURE – No copied signatures accepted
			TOTAL DUE →	**$**	**ALL VOUCHERS MUST BE SUBMITTED BACK TO RESPITE SPECIALIST AT COMMUNITY MENTAL HEALTH – 'A' BUILDING FOR PROCESSING**

Note: *By submitting this 'signed' voucher, you are stating that you are in accordance with the education/training you and your provider(s) received through CMHOC. And, that you also understand that Respite service is a federally funded program and there may be a request for pay back of any funds found used for purposes other then those stated in your training,*	
Parent/Guardian Signature- (Must have original signature – **Do not use pencil** – Copied signatures not accepted) _____	**(Date)**
By signing above I confirm that all Respite Services by my employee/provider are accurate and true.	

Parent/Guardian: If you have a CHANGE in your information, please indicate the NEW information below:

Street Address	
City/State/Zip	
Telephone Number	*Date Change Occurred*

Form amended: MARCH 2014 MB+