



Alliance for
Community
Respite
Care



Request for Reimbursement

Date: _____

Service Recipient (Family or Legal Guardian)

Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Send Service Recipient Reimbursement Invoice to: Alliance for Community Respite Care of UCP/CLASS
Invoice must be received within 30 days after services.

Date of Service	Description	Hours	Rate	Amount
				\$
				\$

Signature of Parent or Guardian Date

Signature of Respite Care Provider Date

Respite Provider: _____

Print Name and Address: _____

