Fiscal Intermediary Services for Self-directed Supports

FAMILY REIMBURSED RESPITE REPORT

SD Participant Name:_______________________________ Month/Year (mm/yyyy):_________________________________

Check Payable To (SD Participant/Parent/Designee, Employer ONLY):

Print Name:____

Print Address:____

Name of Person Providing Respite:____

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

Date of Expense mm/dd/yyyy	Time IN indicate am/pm	Time OUT indicate am/pm	Total Hours Worked	Hourly Rate	Amount Paid
				Total Amount Paid:	

I certify that the above hours of Respite Services were provided for the Participant noted above:

_______________________________________ _____________________________

Signature of Person Providing Respite (required) Date (mm/dd/yyyy)

_______________________________________ _____________________________

Signature of Participant/Designee (required) Date (mm/dd/yyyy)

****NOTE:**

1. Form must be submitted MONTHLY, on the **10th** of the month following the Month expenses occurred.

For FI Use Only
Person Centered Care Services
150 Granite Avenue Staten Island, NY 10303

Date Received:____________

Rev. 7/14/16