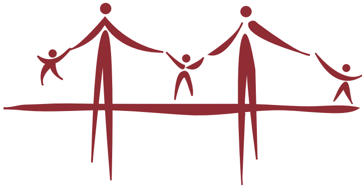

Request for Respite Care Reimbursement
Alliance for Community Respite Care
P.O. Box 15477
Pittsburgh, PA 15237
Phone: 800-876-7607
412-655-8616

Date:____

Service Recipient (Family or Legal Guardian)

Name:____

Address:____

City, State ZIP: ____

Phone: ____

Send Service Recipient Reimbursement Invoice to: Alliance for Community Respite Care
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:__________________________________

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