Department of Intellectual & Developmental Disabilities

RESPITE SERVICES INVOICE

Respite Provider Name:	
Respite Provider Signature:	
Respite Provider Phone #:	
Services Provided to (Child's Name):	

Date(s) of Service (*MM/DD/YYYY*)	**Start Time**	**End Time**	**# *of* Hours**	**Rate charged** (*per hour*)	**Amount Invoiced**

Total Hours of Sessions/Services:	
Total Invoice:	

Name of Parent or Guardian (please print):	
Signature of Parent or Guardian:	
Date Signed:	

PLEASE NOTE:

*Provider **must** be 18 years of age or older.*

*Claim is to be filed under "**Medical**".*

One invoice can be submitted monthly if the same provider provides respite services multiple times in the same month.