RESPITE CARE BILLING FORM

TO: GEAUGA COUNTY JOB AND FAMILY SERVICES
12480 RAVENWOOD DRIVE
P.O. BOX 309
CHARDON, OH 44024

FROM: ________________________
____
____
PHONE: ________________________

RE: RESPITE CARE FOR: (Month) ___________________ (Year) _________________

CHILD #1:	
1.	17.
2.	18.
3.	19.
4.	20.
5.	21.
6.	22.
7.	23.
8.	24.
9.	25.
10.	26.
11.	27.
12.	28.
13.	29.
14.	30.
15.	31.
16.	

CHILD #2:	
1.	17.
2.	18.
3.	19.
4.	20.
5.	21.
6.	22.
7.	23.
8.	24.
9.	25.
10.	26.
11.	27.
12.	28.
13.	29.
14.	30.
15.	31.
16.	

Number of hours for month: ____________Hours
Amount per hour: $_____________
Amount for month: $________________

Number of hours for month: ____________Hours
Amount per hour: $_____________
Amount for month: $________________

_________ Provider to be paid by Geauga County Job and Family Services

_________ Family to be reimbursed by Geauga County Job and Family Services. I, the provider, agree that I have received the above amount listed on the billing form from the family for respite services provided.

Parent (Print Name): ________________________________ Parent Signature: ________________________________

Provider (Print Name): ______________________________ Provider Signature: ______________________________

The submission of this form for payment is an understanding that public funds are being used and the fraudulent use of public funds is a crime. Anyone caught fraudulently reporting or misusing public funds will be prosecuted and will not be eligible for further assistance.