BILL for RESPITE CARE SERVICES

Mail to: The Arc Mid-Columbia – Respite Fund
PO Box 521 The Dalles, OR. 97058

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Name of Person who provided Respite Care

____
Address
____

Telephone number::____

Individual's name who was cared for________________________age_____

Times and Date of Respite Care Service
e.g. 8:00 Am October 5, 2010

Total Hours or Days of Respite Care Services: ___________

Hourly or (daily) Rate: $ ____________

As a Family Caregiver I am requesting $__________from The Arc of the Mid-Columbia Respite Care Fund to help pay for the above respite care services.

X____
Signature of **Respite Care Provider** Date

X____
Signature of **Family Caregiver** Date

Family's phone number____________________

Family's Mailing Address____

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