RECEIPT OF PAYMENT
RESPITE SERVICES

INDIVIDUAL'S NAME: _____

DATE MM/DD/YY	TYPE OF SERVICE (PLEASE LIST)	# OF HOURS	COST PER HOUR	TOTAL PAID
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
		X	= $	.
TOTAL				.

PROVIDER OF SERVICES:	
NAME	
STREET ADDRESS	
CITY, STATE, ZIP	
TELEPHONE #	

I have received a check ☐ or cash ☐, in the amount of $ _____.____, in payment for services as described above.

_____ _____
Provider's signature Date

Family Reimbursement Program