

ADOPTION RESPITE BILLING FORM



Date: _____

Adoptive Parent(s) Names: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number (Cell): _____ Phone Number (Home): _____
 Email Address: _____

Name of Person Providing Respite: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number (Cell): _____ Phone Number (Home): _____
 Is Provider an adult (age 18 or older)? _____ Email: _____

Respite care is being provided for the following adoptive children:

Name	Medicaid ID #	Age	Male/Female
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Dates Requesting Respite: Beginning date: _____ Ending date: _____

Number of Respite Days Completed: _____

By signing below I certify that the above Respite Services were provided during the time stated above and that the children receiving adoption respite have had a finalized subsidized adoption. This form must include signatures in order to be processed.

Signature of Adoptive Parent: _____ **Date:** _____

Signature of Respite Provider: _____ **Date:** _____

IMPORTANT - Adoption Respite is a program available to adoptive families for their subsidized adopted children. Each adopted child who receives a subsidy is eligible to receive five days of respite care per fiscal year at \$20 per day. After respite services have been provided, the adoptive parent should complete this form and submit to IFAPA. The current fiscal year for the Adoption Respite Program runs from July 1, 2014 to June 30, 2015. All respite days must be used during these dates and the completed form must be submitted to IFAPA no later than July 10, 2015. Please allow one week for processing.