Your Challenge… Our Commitment

EEDA FAMILY REIMBURSEMENT PROGRAM

RECEIPT OF PAYMENT

Individual's Name: _____ Medicaid #: _____

Family Name: _____ **Month:** _____ **Year:** _____

Address: _____ **Phone#:** _____

Date	Hours Used	Staff's Name/Receipts	Amount Paid	Parent/Guardian Signature
		TOTAL ---		

I have received payment for providing Respite Care:

Staff Name and Signature: _____

Staff Address: _____

FI Signature:

Date:

1/2/2013

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