



Creating Opportunities for Happy Lives!

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