

Respite Days Reimbursement Form
Forms are available online at www.panhandlepartnership.com

Respite Provider Information

Name of Authorized Provider: _____

Mailing Address: _____

City: _____ State: NE Zip Code _____

Phone Number: _____ Email Address: _____

If you do not have a background check on file with the Respite Program you will not be reimbursed. If you need a form please call 866-RESPITE.

Caregiver Information (Spouse, Parent, Guardian)

Name: _____

Mailing Address: _____

City: _____ State: NE Zip Code _____

Phone Number: _____ Email Address: _____

Forms must be submitted by the last day of the month you are requesting reimbursement form. Late forms may not be paid.

Who is Receiving Respite Care? (This is your family member who has a life-long disability and cannot be left alone)

Name: _____ Name: _____

Date of Birth: _____ Date of Birth: _____

Diagnosis: _____ Diagnosis: _____

*Please be sure your provider has emergency contact numbers and medication information if appropriate.

Reimbursement Rate – Maximum allowed is 8 hours per person or \$100 max for family

Please list the date of Respite Day being reimbursed _____

Participant #1 _____ hours * \$8.00/hr = _____

Participant #2 _____ hours * \$8.00/hr = _____

Total of lines above or \$100 if total is greater than \$100 _____

Mail form to WCHR Respite Program, 821 Morehead St., Chadron NE 69337. Please note we process checks two times a month. Forms received by the 5th of the month should be received by the 15th. Forms received by the 20th of the month should be received by the 30th. Please do not call before that time.