

Send Voucher to: CEI/CMH, ATTN: Carisa Visser, 812 E. Jolly, Suite 114, Lansing, MI 48910

RESPIRE CARE REIMBURSEMENT VOUCHER

(Will not accept more than one month or one care provider per voucher.)

Parent/Guardian _____ Adult/Child Consumer _____

Address _____ City/Zip _____ Phone # _____

Change of Address? Yes No Medicaid Enrolled? Yes – Medicaid # _____ No

READ RESPIRE AGREEMENT AND INSTRUCTIONS ON BACK BEFORE COMPLETING

DATE	TOTAL HOURS	TIME IN	TIME OUT	CARE PROVIDER SIGNATURE	(\$100.00 maximum daily charge and \$10 maximum hourly charge) AMOUNT
COMMENTS:				TOTAL CARE PAYMENT	
				For Office Use Only	LESS FAMILY CO-PAY ()
				For Office Use Only	NET CHECK AMOUNT

I understand and assume full responsibility for the accuracy and legitimacy of all hours and payments listed above, and also for the proper payment thereof.

PARENT/GUARDIAN SIGNATURE: _____

FAMILY FRIEND/CARE PROVIDER TO COMPLETE THE BELOW INFORMATION:

<u>Family Friend/Provider Signature</u>	<u>Address, City, State and Zip Code</u>	<u>Area Code with/Telephone No.</u>
Signature: _____	<input type="checkbox"/> Change in Address	
Print Name: _____		

For Office Use Only	
Consumer # _____ <input type="checkbox"/> zz1244 <input type="checkbox"/> zz1092	CSDD Signature: _____ Date Faxed _____
Finance Approval _____ [Cost: 87701 or _____ Account: 805010 Percent: 100%]	

THIS DOCUMENT IS SUBJECT TO AUDIT

RESPITE AGREEMENT AND INSTRUCTIONS: PLEASE READ BEFORE COMPLETING THIS FORM

- 1.) Forms must be completed in detail with each day listed on a separate line with the time in and time out. All signatures and requested information must be filled in on the voucher.
- 2.) For families **not enrolled** (Non-Medicaid) in the Fiscal Intermediary (FI) service; you pay your family friend first, complete this form and mail it in for payment. **Vouchers submitted more than 30 days after services were provided will not be paid.**
- 3.) For families **enrolled** (Medicaid) and receiving Fiscal Intermediary (FI) services; this form is completed, mailed to our office, and the care provider/family friend is paid directly. Vouchers must be submitted no later than the 5th day of the month following service provided.
- 4.) Forms that are not completed correctly will be returned to you and payment will not be made until the form is returned to our office with the requested changes.
- 5.) When using respite care you are agreeing to provide the family friend/care provider with the provisions necessary to provide care including; emergency information, medical treatments, and general or special care guidelines.
- 6.) PLEASE NOTE: All vouchers for September must be submitted no later than October 31st to receive payment.
- 7.) **RESPITE AGREEMENT: As a parent/guardian enrolled in the Family Friend or Fiscal Intermediary Respite Program you agree to the following:**
 - Hire providers who are able to follow the child's/adult's plan of care and the training given by the parent/guardian or responsible relative of the child/adult receiving respite care;
 - Are able to prevent transmission of any communicable disease from self to others;
 - Are able to communicate effectively;
 - Hire providers who are 18 years of age or older.
 - Not reimburse immediate family including; father, mother, sibling, aunt, uncle, or grandparent living in the same household, under no circumstances can biological or adoptive parents be eligible for respite care enrollment or reimbursement;
 - Recommended annual TB testing for the provider;
 - ***Submit vouchers signed by the parent/responsible party and signed by the care provider for each day; verifying the date, hours and payment amount for the services provided. Please make sure that the Parent/Guardian signs on the signature line provided and the Respite Provider signs in the signature box provided along with address and telephone number.***

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