



Nebraska Respite Network Southwest Service Area

Request for Emergency/Un-reimbursed Respite Funds

P O Box 1235, McCook NE 69001

Phone (308) 345-4990 * Fax (308) 345-4289

I _____ would like to request funds to cover respite care for _____. Care will be provided by _____ on the following times/days: _____.

Explanation of need for Emergency Respite: (Please be specific)

(Caregiver/Parent/Guardian)

(Respite Provider)

The request form must be completed and signed by the caregiver, respite provider, or a professional working directly with the client. The completed form must be approved by the respite coordinator prior to the beginning of care or, under special circumstances, on the following business day. Persons may apply for up to \$250 per crisis or a maximum of \$500 per year. Every effort must be made to find respite funding for the client prior to requesting emergency respite funds. The provider chosen by the caregiver must be approved by a Nebraska Respite Network Representative.

Date / Approved by Coordinator

BILLING DOCUMENT EMERGENCY RESPITE

Client Name(s): _____ **Phone:** _____

Address: _____

Provider Name: _____ **Phone:** _____

Address: _____

DATES OF SERVICE	TOTAL NUMBER OF HOURS	PRICE PER HOUR/DAY	TOTAL AMOUNT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL BILLED			_____
			Not to exceed \$250.00

Person to be Paid _____

The Client/Parent/Guardian/Authorized Representative must verify that this billing is accurate. Anyone who files a false claim may be persecuted for Fraud. **BILLS MUST BE SUBMITTED WITH IN 30 DAYS OF THE DATE OF SERVICE.**

Provider Signature

Date

Client/Parent/Guardian/Authorized Representative Signature

Date

Approval of Respite Coordinator _____ Date _____