



Nebraska Respite Southwest Service Area

Request for Emergency/Un-reimbursed Respite Funds

Billie Cole-Respite Coordinator

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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 will be:

Request for emergency or un-reimbursed respite funds must be made by the caregiver(or coordinator/caseworker working with family) of a client who has a long-term or lifelong disability or illness. The caregiver may apply for up to \$250 per crisis or a maximum of \$500 per year. Every effort must be made by the caregiver and coordinator to find respite funding for the client prior to requesting emergency respite funds. The provider chosen by the caregiver must be approved by the Nebraska Respite Network or agency coordinator/caseworker.

/

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 _____