



# Nebraska Respite Network Southwest Service Area

## Respite Days Reimbursement Form

Forms are also available online at [www.swhealthdept.com](http://www.swhealthdept.com)

### Respite Provider Information

Name of Authorized Provider: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: NE Zip Code \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Only providers with all necessary background checks on file with The Nebraska Respite Network will be reimbursed for services. If you need a form please call 1866RESPITE or 308.345.4990

### 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 for. Late forms may not be paid.

### Participant 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. We have documents available to assist with gather this information call 1866RESPITE or 308.345.4990 for more information

### Reimbursement Information

Date of Respite Day: \_\_\_\_\_

Participant #1 \_\_\_\_\_ hr x \$ \_\_\_\_\_ = \_\_\_\_\_

Participant #2 \_\_\_\_\_ hr x \$ \_\_\_\_\_ = \_\_\_\_\_

**Total amount to be reimbursed:** \_\_\_\_\_

Party to receive payment (circle one): Provider \* Caregiver

Reimbursement Rate: Maximum allowed is 8 hours per person and \$100 per household. Please allow 30 Days to receive payment for services.

Signature of Caregiver \_\_\_\_\_ Date : \_\_\_\_\_

Signature of Provider \_\_\_\_\_ Date: \_\_\_\_\_

Approval of Coordinator \_\_\_\_\_ Date: \_\_\_\_\_