CSNN RESPITE EXPENSE VOUCHER

Return to: Children's Special Needs Network
204 N. East St., Suite F
Belton, Texas 76513
Fax: 254-933-7313

INSTRUCTIONS: *Please complete each section of the voucher for each respite visit. DO NOT USE any kind of WHITE OUT on form! Please return completed voucher to the CSNN office.*

Parent's/Guardian's Name: _____Phone # _____

Address:_____

Child(s) Name: _____

Place where respite will be provided:

Address: _____

Respite Provider's Information:

Name: _____

Address: _____

Phone: _____ Relation to child: _____

Checks will be mailed to the parent/guardian. They are responsible for paying provider.

SERVICE DATES	START TIME	END TIME	PAY RATE	NUMBER OF HOURS	TOTAL AMOUNT PAID TO PROVIDER	REQUIRED PROVIDER'S Initials	REQUIRED PROVIDER'S PHONE NUMBER
TOTALS							

I (parent/guardian) certify that the above information is correct and that respite care services were provided to the individual named. **I understand that I am responsible for paying the respite provider** the amounts listed above.

Parent/Guardian Signature: _____Date:_____

Provider Signature: _____Date: _____