Adult and Child Mental Health Center
TFC Respite Provider Payment Request

***Name of Respite Provider*:** _____
**** Reminder this must be a licensed foster home****

Contact Information & Address (If outside of A&C Network of foster homes)

_____

Name of licensing agency, if not A&C: _____

Date/Time of Respite: *Date/Time of Arrival* _____*am/pm*

Date/Time of Departure: _____*am/pm*

Level of Respite: *(Check one)* ❑ *Standard* ❑ *CA-PRTF*

Calculate Respite Payment

A) Rate Per Day Per Child*:* _____ *Standard Rate is $40 / PRTF Rate is unpublished*

B) # of Children: ***X*** _____ *Children listed at bottom of form*

C) TOTAL Rate: _____ *Multiply lines A & B*

D) # of days (overnights): ***X*** _____ *Number of overnight stays (unless daytime respite)*

E) TOTAL Payment: _____ *Multiply lines C & D for the Payment*

Child(ren) for Who Respite was Provided:

Name(s): _____

_____

I am reporting (one of the following boxes must be marked):

☐ Paid Respite ☐ Other:_____

Signature of Respite Provider:_____

*CA-PRTF respite must be over 7 hours to receive reimbursment