OPWDD REGION 1 FAMILY REIMBURSEMENT RESPITE VERIFICATION FORM

- This form **must** be signed by the respite provider and the parent/family member where indicated to be eligible for reimbursement. **PLEASE COMPLETE ALL AREAS IN FULL FOR FORM TO BE ACCEPTED.**
- All Respite Providers are to be **14 years of age** or older.
- If respite provider is a family member, he/she must maintain a residence **outside of the individual's home**.

PARTICIPANT: Name:_____ Date of Birth: _____

PARENT/GUARDIAN: Name: _____
Address_____
_____Zip:_____
Telephone: _____

RESPITE PROVIDER: Name: _____Relationship:_____
Address: _____
_____ Zip: _____
Telephone: _____

Date Service Provided (m/d/y)	Time In	Time Out	Number Of Hours	Rate Paid Per Hour	Total Amt. Paid Per Day	**Provider's Initials**

Total Hours (this page): _____ Total Amount asking to be reimbursed (this page): $_____

****PLEASE SEE NEXT PAGE FOR REQUIRED SIGNATURES AND INFORMATION****

Does this respite provider also work for an agency to provide HCBS Waiver In-Home Hourly Respite for your child? Yes ___ No___

*If so, please note that Family Reimbursement cannot be used to supplement the hourly respite rate of pay and therefore the hours cannot be duplicated.

Agencies will conduct random spot checks for respite applications; respite providers will be contacted to verify hours and payment.

In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.

*I HAVE READ THE STATEMENT ABOVE AND CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE: (Signatures must be original)

Respite Provider's Signature: _____ Date _____

Parent/Guardian Signature: _____ Date: _____