The ALS Association Northern Ohio Chapter
Respite Care Program Reimbursement Request

Respite forms are due monthly. *Complete a request form for each month and return it to the Chapter prior to the 15th of the following month. Please attach a copy of your billing statement or a Respite Hours Tracking form.*

Name of person to receive check (*not hired caregiver*): _____

Primary Caregiver/Power of Attorney: _____

Name of person with ALS/MND: _____

Address: _____

City/State/Zip: _____

Phone: _____

Date of request: _____ **Month of Service**: _____

Hourly Rate: _____ Hours provided: _____ (program is limited to 8 hours/calendar month)

In order to provide reimbursement for services, we require the contact information for the service provider. We cannot reimburse without the following information used for Chapter purposes

Qualification Level *(please circle)* HHA STNA LPN RN

Agency *(if applicable)*:_____

Name of Provider: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell: _____

Signature of Provider: _____

FOR OFFICE USE ONLY

Account: 5825 Class: P & S

Date: _____

Total Amount: _____ Payable to: _____

Requested by: _____ Authorized by: _____

THIS FORM MAY BE SUBMITTED BY:
Email: respite@alsaohio.org
FAX: 216-592-2575
MAIL: The ALS Association Northern Ohio Chapter
Respite Program
6133 Rockside Road, Suite 301
Independence, OH 44131

Form Updated 11/2020