Wildwood Programs Family Support Services
Respite Reimbursement Log

Child's Name: _____ Date Submitted: _____

Staff Name: _____

Staff Address: _____ Staff Phone#: _____
_____

Date	Name of Staff	# of Hours	Rate of Pay	Amt. Paid	Signature of Staff
	TOTAL HOURS				

Total Amount: $_____

Reimbursement to: Parent Name_____
Address_____
City, State, Zip_____
Telephone # _____

I _____ affirm that the above information is complete and accurate.
(parent signature)

Please return log to: Wildwood Programs
1190 Troy-Schenectady Rd.
Latham, NY 12110
Attn: Heather Giorgianni