Wildwood
Respect. Integrity. Creativity. Holism.

**Family Support Services**
**2020 Respite Reimbursement Log**

**Individual Receiving Respite: _____ Date Submitted: _____**

**Staff Name: _____**

**Staff Address: _____ Staff Phone#: _____**

**_____**

| Date | Name of Staff | # of Hours | Rate of Pay | Amt. Paid | Signature of Staff* *By signing this form, you are verifying that you were paid the indicated amounts. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | **Please total hours =** | | | | |

**Total Amount: $ _____**

**Reimbursement to:** **Parent/Caregiver Name _____**
**Address:_____**
**_____**
**Telephone Number: _____**

**_____ I affirm that the above information is accurate and that I have paid**
**(parent/caregiver signature) staff the amount indicated above for Respite.**

**Please return by email, fax, or mail;**

**HGiorgianni@wildwoodprograms.org Fax: 518-640-3307**

**Wildwood Programs, 1190 Troy-Schenectady Rd., Latham, NY 12110**
**Attn: Heather Giorgianni**