Family Support Services
2021 Respite Reimbursement Log

Individual Receiving Respite: ____________________ Date Submitted: ___________

Staff Name: ______________________________

Staff Address: _______________________________ Staff Phone#: _______________

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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