



**Family Support Services
2022 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: _____

 (parent/caregiver signature) **I affirm that the above information is accurate and that I have paid staff the amount indicated above for Respite, and it is atleast NYS Minimum Wage.**

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