



# The Moore Center

Creating opportunities for a good life.™

195 McGregor Street, Unit 400  
Manchester, NH 03102

## Respite Voucher

**PROGRAM:**  In Home Supports  Family/Consumer Directed Services  CCW  Regular

**RESPITE** is short-term and temporary care provided to an individual so his or her primary caregiver(s) are furnished a break from their care-giving responsibilities.

**INSTRUCTIONS:** Reimbursement can only be made *after* services have been provided and only upon receipt of this voucher *completed in its entirety*. ALL respite providers must be approved prior to providing service. A family's direct payments to provider(s) may have tax and liability implications for both parties. It is important to track payments made to providers for determining provider's employment status and both parties' tax obligations. *Please use a separate form for each provider and each calendar month. Mail, fax (622-4278 or 668-5443), or deliver this completed form to the attention of:* \_\_\_\_\_.

Client's Name: \_\_\_\_\_ Provider's Name: \_\_\_\_\_

### Make Payment To:

Name: \_\_\_\_\_ Telephone:  \_\_\_\_\_  
Please check if new

Address:  \_\_\_\_\_  
check if new Street City State Zip

### Relationship of Payee to Client:

Biological Parent  Non Biological Parent  Provider  
 Other Family (Explain) \_\_\_\_\_  Non Family (Explain) \_\_\_\_\_

**Month** services were used: \_\_\_\_\_ **Year:** \_\_\_\_\_

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	TOTAL
Number of Hrs*																	
Day of Month	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		TOTAL
Number of Hrs*																	

\* - Round to the quarter hour

**Total Hours:** \_\_\_\_\_ x **Rate Per Hour:** \$ \_\_\_\_\_ = **Total:** \$ \_\_\_\_\_

**Billing Deadlines:** In most instances, if vouchers are received by Tuesday, checks will be processed and ready that Friday.

\_\_\_\_\_  
**Provider's Signature**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Print Name**

<b>FOR PROGRAM USE ONLY</b>		<b>Program Line Item:</b> _____	<b>Cost Center:</b> _____
Signature of Case Manager	Printed Name	Date	
Signature of Authorization (if applicable)	Printed Name	Date	