**Georgia Hope Inc.**

**FAX: Respite Request & Reimbursement Form** 9.30.2016

|  |  |
| --- | --- |
| To |  , Georgia Hope Caseworker |
| Fax No. | (678) 609-5407 or (678) 342-2669 |
| From |  |
| Re: | **Respite Request & Reimbursement** |
| Date |  |

**Respite Request & Reimbursement Form**

**(2 weeks advance notice)**

|  |  |
| --- | --- |
| **Foster Parent:** | Contact No.: |
| Address: |
| City Sate Zip: |
| **Child’s Full Name:** | **DOB:** |
| Reason for Care: |
| **From (Date):** | **To (Date):** |
| From (Time) am/pm | To (Time): am/pm |

**Approved Respite Provider Requested: (optional)**

|  |  |
| --- | --- |
| **Provider Name:** | Contact No.: |
| Address: |
| City State Zip |

**Foster Parent Signature Respite Provider Signature**

|  |  |
| --- | --- |
| Signature | Signature |
| Printed Name | Printed Name |
| Date | Date |

**NOTE: Respite reimbursement will be paid to the respite provider. Respite requests must be made at least 2 weeks in advance. Reimbursed requests to the foster parent must be made 30 days in advance and is paid upon receipt from the State office which may take up to 45 days. Respite care provided after 7pm includes an additional day to the provider. A Respite Placement Form must be provided to respite provider at time of placement.**