RESPITE SERVICES LOG

To be reimbursed for respite care, you must complete this service log or we must have an invoice from the agency providing the service. ***Please complete a separate form for each care provider.*** *All information must be filled out..*

Office Use Only

Grant Number: _____

Amount: $ _____

Hours: _____ x 4 = _____units

Remaining Balance: _____

Caregiver Name: _____

(Caregiver is the person who applied for this grant)

Care Recipient Name: _____

(**Care Recipient** is the patient, the person receiving the care)

Care Provider: _____

(Care Provider is the person or agency hired by the caregiver to provide the patient's care)

A COPY OF THEIR DRIVER'S LICENSE MUST BE ATTACHED TO EVERY SERVICE LOG (UNLESS AGENCY INVOICE IS ATTACHED)

(DATE OF SERVICE CANNOT BE BEFORE THE APPROVAL DATE LOCATED ON YOUR APPROVAL LETTER)**

**DATE OF SERVICE	# HOURS		Can be any amount you choose. HOURLY RATE		DAILY TOTAL
		x	$	=	$
		x	$	=	$
		x	$	=	$
		x	$	=	$
		x	$	=	$
		x	$	=	$
		x	$	=	$

Multiply # of hours by hourly rate to get the total for the day

Total Hours: _____ Total Amount: _____

Care Provider's Signature _____ **Birthdate:** _____

The person who is hired to provide the patient's care must be at least 18 years old a **copy of their driver's license must be attached.** Complete a form for **each** care provider.

Make Check Payable To: _____

Mailing Check To: _____

City, State, Zip code: _____

Caregiver Signature _____ Date: _____

Payment or reimbursement will usually be within **15 business days** from the date the Service Log, invoice or receipt is received in the Alzheimer's Arkansas office.

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