Monthly Respite

Child/Adult receiving Respite: ______________________________

Make Check Payable to: ______________________________

Current Address: Check here if new address

____
____
____

Please add e-mail address below:

____

Do you / your child have NH Medicaid? NO YES Number: ______________________________

*Please **check** the month you are submitting for (indicates due date).*

July *(Aug 15)*	Aug *(Sept 15)*	, Sept *(Oct 15)*	Oct *(Nov 15)*	Nov *(Dec 15)*	Dec *(Jan 15)*
Jan *(Feb 15)*	Feb *(Mar 15)*	March *(Apr 15)*	April *(May 15)*	May *(June 15)*	June *(June 1)*

Please use the space below to document respite services during this month.

Date of Respite	Provider (person caring for the child/adult)	Total Hours
	Total Hours	

Please reimburse me for the respite expenditures noted above.

____
Signature of parent/legal guardian

Please submit the completed form to Community Crossroads, Inc Attn: Rochelle Dumont, 8 Commerce Dr, Atkinson NH 03811
or e-mail this form to rdumont@communitycrossroadsnh.org and add "respite" in subject line.

FOR OFFICE USE ONLY		
Medicaid Hrs.:	Amount Due:	Non-Med. Hrs.: