Adult and Child Mental Health Center
TFC Respite Provider Payment Request

Name of Respite Provider: ____

**** Reminder this must be a licensed foster home****

Contact Information & Address (If outside of A&C Network of foster homes)

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Name of licensing agency, if not A&C: ____________________________________

Date/Time of Respite: *Date/Time of Arrival* _____________*am/pm*

Date/Time of Departure: _____________*am/pm*

Level of Respite: *(Check one)* ❑ *Standard* ❑ *CA-PRTF*

Calculate Respite Payment

A) Rate Per Day Per Child: ____________ *Standard Rate is $25 / PRTF Rate is unpublished*

B) # of Children: ***X*** ____________ *Children listed at bottom of form*

C) TOTAL Rate: ____________ *Multiply lines A & B*

D) # of days (overnights): ***X*** ____________ *Number of overnight stays (unless daytime respite)*

E) TOTAL Payment: ____________ *Multiply lines C & D for the Payment*

Child(ren) for Who Respite was Provided:

Name(s): ____

____

I am reporting (one of the following boxes must be marked):

☐ Paid Respite ☐ Other:_____________________________

Signature of Respite Provider:____________________________________

*CA-PRTF respite must be over 7 hours to receive reimbursment