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)
________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Calculate Respite Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Rate Per Day Per Child: _________  Standard Rate is $25 / PRTF Rate is unpublished</td>
</tr>
<tr>
<td>B) # of Children: X ___________ Children listed at bottom of form</td>
</tr>
<tr>
<td>C) TOTAL Rate: ___________  Multiply lines A &amp; B</td>
</tr>
<tr>
<td>D) # of days (overnights): X ___________ Number of overnight stays (unless daytime respite)</td>
</tr>
<tr>
<td>E) TOTAL Payment: ___________ Multiply lines C &amp; D for the Payment</td>
</tr>
</tbody>
</table>

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 reimbursement*