INVOICE FOR RESPITE SERVICES

PARENT'S NAME: ______________________

CHILD'S NAME: ______________________

ADDRESS: ______________________

TELEPHONE NUMBER: ______________________

DIRECT SUPPORT PROVIDER NAME: ______________________

PLEASE SELECT ONE OPTION TO INDICATE THE TYPE OF FUNDING YOU WISH THIS INVOICE TO BE PAID FROM ☐ RESPITE OR ☐ AUTISM RESPITE

DATE SERVICE PROVIDED	# HOURS OF SUPPORT RECEIVED	HOURLY RATE CHARGED/PAID
TOTAL:		

TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT______________________

Signature of Parent/ Guardian: ______________________ Date

Signature of Direct Support Provider: ______________________ Date

(THIS IS A SAMPLE INVOICE)

INVOICES CAN BE DELIVERED TO FAMILY RESPITE SERVICES
3295 QUALITY WAY UNIT 101A
WINDSOR, ON N8T 3R9
INVOICES CAN BE FAXED TO: 519-972-8902
FURTHER ASSISTANCE PLEASE CALL: 519-972-9688