

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

INVOICES CAN BE DELIVERED TO FAMILY RESPITE SERVICES
2565 Ouellette Avenue, Unit 150
WINDSOR, ON N8X 1L9
INVOICES CAN BE FAXED TO: 519-972-8902
FURTHER ASSISTANCE PLEASE CALL: 519-972-9688