Reeve Grant Respite Reimbursement Application

Caregiver Information:

Name:			**MALE or FEMALE**
Mailing Address:			
City:	**State:**	**Zip:**	**County:**
Phone Number:		**Email:**	

Who do you care for?

Name:		**MALE or FEMALE**
Date of Birth:	**Age:**	
Diagnosis:		
Relationship to the person you care for:		

Please circle any respite services you are currently receiving:

Medicaid Waiver Home Based Services (Personal Care, Homemaker, Companion, etc.)
Alabama Cares Voucher Program
UCP Hearts Voucher Program
Alabama Head Injury Foundation

Please read carefully and initial each blank below:

____ I understand that in order to receive reimbursement for respite services, my voucher form must be completed and returned by the due date provided.
____ I understand that I am responsible for selecting and training a trustworthy respite provider who is 18 years of age or older and living outside of the care recipient's home. Alabama Respite nor UCP will be held responsible for any actions taken by my selected respite provider.
____ I understand that the reimbursement check will be mailed to the address submitted on the voucher form, and that there is a 30 day waiting period before I receive reimbursement.
____ I understand that if asked, I will need to provide proof of diagnosis before being reimbursed.
____ I agree to use the funds ONLY for respite care.

Caregiver Signature: _____ Date: _____

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