Respite Care Provider Log (For Non-Professional) To be included with *Request for Funds* form

This is reimbursed to person with ALS

Respite Care *is the temporary relief for a primary caregiver, enabling them to take a much-needed break from the demands of caregiving*

***Please Note: Service Provider must attach a copy of ID (license/government issued or a utility bill with the address that must match the address below)**

Non-Professional Care Provider Name (Print): _____

Street Address: _____
(cannot live in same residence as person with ALS)

City: _____ State: _____ Zip: _____County: _____

Phone: _____ Email: _____

Signature of Care Provider: _____

Date (list separately on each line)	Time In:	Time Out:	# of Hours

Total # of Hours _____ x hourly rate $_____ = Total Amount Paid for Services: _____

By Signing below, I acknowledge that the above information is true, correct and complete.

Person with ALS Name (Print): _____

*Signature: (person with ALS or Caregiver:*_____

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