Respite Care Provider Log (For Non-agency) 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-agency 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. I also acknowledge that if I provide false information, I will no longer be able to receive funds for Respite Care that is not provided by a professional agency.

Person with ALS Name (Print): _____

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