



## Respite Care Provider Log

**\*FOR NON-PROFESSIONAL RESPITE PROVIDER ONLY\***

***Must be submitted with a completed reimbursement request form.***

***Care provider cannot live in same residence as person with ALS.***

**Provider Information: Must be completed and signed by non-professional care provider**

***(Further Care Provider information may be requested)***

Non Professional Care Provider Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Signature of Care Provider: \_\_\_\_\_

Date	Time In:	Time Out:	# of Hours	Type of Care Provided

**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: \_\_\_\_\_

Date: \_\_\_\_\_