

Respite Care Provider Log (non-agency)

To be included with *Request for Funds* form

To receive reimbursement, please answer the following questions:

Overall, how helpful will the respite care grant be in providing care for the person with ALS?

Significant Considerable Moderate Minor None

Overall, will the respite care grant make a positive difference in your life?

Yes Somewhat No

Overall, will the respite care grant help lower your stress level?

Yes Somewhat No

Non-agency Provider Name (Print): _____

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

Phone: _____ Email: _____

Signature of Care Provider: _____

Date	Time In:	Time Out:	# of Hours	Type of Care Provided (personal care only)
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: _____