

## Respite Claims Detail Invoice

Parent/Guardian  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Stuart Wilson Contracted Through  
 Bay-Arenac Behavioral Health  
 Behavioral Health Center  
 201 Mulholland  
 Bay City, MI 48708  
 989-895-2300**

I hereby certify that all RESPITE providers listed below have received training and/or all pertinent information and is qualified to provide care for **Consumer/Employer:** \_\_\_\_\_. I understand that Bay-Arenac Behavioral Health is not responsible for the actions of the worker or the child/adult while care is being provided. **\*If the Respite provider has an address change it must be indicated on the Respite invoice!**  
**••Dates submitted cannot be more than 3 months old\*\***

Respite Care Worker PLEASE PRINT SIGNATURE ON FIRST LINE and SIGN THE REST	Date of Service	Start Time AM/PM	Stop Time AM/PM	Total hours	Hourly Rate	Total Reimbursement	Progress Note

I understand and assume full responsibility for the accuracy and legitimacy of all hours listed above. I further declare that respite is not being used for the primary reason of care during my regular hours of employment. Respite care invoices can be returned to Susan Curtis at [E-mail to:scurtis@babha.org](mailto:scurtis@babha.org)  
**\*within three months of care.**

Signature of Parent/Guardian: \_\_\_\_\_