RESPITE CLAIMS DETAIL INVOICE

	Parent/G	Parent/Guardian Name:					Bay	Bay-Arenac Behavioral Health	oral Health
X	`\	Address:						Family Support Program Behavioral Health Center	rt Program ulth Center
_		Phone:						201 N Bay City,	201 Mulholland Bay City, MI 48708
	1.) The Resp	RESPITE PROVIDER QUALIFICATIONS Each respite provider and parent/guardian certifies that the below qualifications have been met at the time of, or before, the respite service is provided 1.) The Respite Aide is trained in the special care needs of the respite participant by the parent. 4.) The Respite Aide is in good standing with the law (i.e. not a fugitive from or an illegal alien).	RESPITE PI fies that the below articipant by the p	DER	QUALIFICATIONS ons have been met at the t 4.) The Respite Aide is in felon, or an illegal alien)	e time of, or before in good standing	re, the respite service; with the law (i.e. n	QUALIFICATIONS Ons have been met at the time of, or before, the respite service is provided. 4.) The Respite Aide is in good standing with the law (i.e. not a fugitive from justice, a convicted felon, or an illegal alien).	989-895-2300 Stice, a convicted
	2.) The Resp	2.) The Respite Aide is at least 18 years of age.			ie Respite Aide is	able to perform	5.) The Respite Aide is able to perform basic first aid procedures	dures	
	3.) The Respite individual performed.	 The Respite Aide is able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific procedures, and to report on activities performed. 	v in order to follo and to report on a	tivities	we Respite Aide is s in the environme	able to prevent t ent in which they	The Respite Aide is able to prevent transmission of any com- others in the environment in which they are providing supports.	 The Respite Aide is able to prevent transmission of any communicable diseases from self to others in the environment in which they are providing supports. 	from self to
7	I hereby c	hereby certify that all RESPITE providers listed below have received training and/or all pertinent information and is qualified to provide care	w have recei	ved training a	•	inent inform	ation and is qua	lified to provide	care
	child/adul	child/adult while care is being provided. *If the Respite provider has an address change **Dates submitted can't be more than 3 months old**	te provider l	f the Respite provider has an address change nore than 3 months old**		must be ind	icated on the F	it must be indicated on the Respite invoice!	or the
	T	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	
	X		-						
								1	
	T								
	T	2							
	T								
	T								
_									*
	eason of ca	reason of care during my regular hours of employment. Respite care invoices can be returned to Susan Leix at BABH Family Sunner Program * int. in principles of care.	and legitimacy pite care invoice	of all hours lisces can be retu	sted above. If	further declare	that respite is not	I further declare that respite is not being used for the primary un Leix at BABH Family Support Program *	e primary
	8						, adda.	William Minister	uree

Signature of Parent/Guardian