



Nebraska Respite Network *Southwest Service Area*

Request for Emergency/Un-reimbursed Respite Funds

I, _____, would like to request funds to cover respite
(Caregiver)
care for _____. Care will be provided by _____

on the following days:

____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

Explanation of need for Emergency Respite: (Please be specific)

The completed form must be approved by the respite coordinator prior to the beginning of care or, under special circumstances, on the following business day. Every effort must be made to find respite funding for the client prior to requesting emergency respite funds. The provider chosen by the caregiver must be approved by a Nebraska Respite Network Representative.

Office use only

Approval of Respite Coordinator _____ Date: __/__/____

BILLING DOCUMENT EMERGENCY RESPITE

BILLS MUST BE SUBMITTED WITH IN 30 DAYS OF THE DATE OF SERVICE.

Client Name(s): _____ Phone: ____-____-____

Address: _____ City: _____ NE Zip Code: _____

Provider Name: _____ Phone ____-____-____

Address: _____ City: _____ NE Zip Code: _____

DATES OF SERVICE	TOTAL NUMBER OF HOURS	PRICE PER HOUR/DAY	TOTAL AMOUNT
_____	_____	_____	\$____.____
_____	_____	_____	\$____.____
_____	_____	_____	\$____.____
_____	_____	_____	\$____.____
_____	_____	_____	\$____.____
		TOTAL BILLED	\$____.____

Person to be Paid _____

**The Client/Parent/Guardian/Authorized Representative must verify that this billing is accurate.
Anyone who files a false claim may be persecuted for Fraud.**

I verify that this billing document is accurate and submit it to the
Nebraska Respite Network for payment.

Name: _____ Date: __/__/____

Office use only

Approval of Respite Coordinator _____ Date: __/__/____