



Respite Days Reimbursement Form

Forms are also available online at www.respitesw.ne.gov

404 West 10th St • PO Box 1235, McCook, NE 69001
Ph: 308-345-4990 • Fax: 308-345-4289
Email: respitesw@swhealth.ne.gov

Respite Provider Information

Name of Authorized Provider: _____
 Mailing Address: _____
 City: _____ NE Zip Code _____
 Phone Number: _____ Email Address: _____

Only providers with all necessary background checks on file with The Nebraska Respite Network will be reimbursed for services. If you need a form please call 1866RESPITE or 308.345.4990

Caregiver Information (Spouse, Parent, Guardian)

Name of Authorized Caregiver: _____
 Mailing Address: _____
 City: _____ NE Zip Code _____
 Phone Number: _____ Email Address: _____

Forms must be submitted by the last day of the month you are requesting reimbursement for. Late forms may not be paid.

Participant Receiving Respite Care

(This is your family member who has a life-long disability and cannot be left alone)

Participant #1: _____ Participant #2: _____
 Date of Birth: _____ Date of Birth: _____
 Diagnosis: _____ Diagnosis: _____

**Please be sure your provider has emergency contact numbers and medication information if appropriate.
 We have documents available to assist with gathering this information call
 1866RESPITE or 308.345.4990 for more information*

Reimbursement Information Party to receive reimbursement: _____

Date of Respite Day: ____/____/____
 Participant #1 ____ hr(s) x \$ ____ = \$ ____
 Participant #2 ____ hr(s) x \$ ____ = \$ ____

Total amount to be reimbursed: \$ ____.

Reimbursement Rate: Maximum allowed is 8 hours per person up to \$100 per household. Please allow 30 Days to receive payment for services.

Provider signature _____	Date: _____
Caregiver signature _____	Date: _____
Approval of Coordinator _____	Date: _____