IDAHO FEDERATION OF
Families
FOR CHILDREN'S MENTAL HEALTH

704 N 7th Street, Boise, ID 83702
208-433-8845 tel 208-433-8337 fax
www.idahofederation.org

RESPITE CARE INVOICE

Parent Name:____

Parent MailingAddress________________________________Phone_______________________

City ___________________________________ State__________ Zip Code_________________

Parent Email ____

Provider Name: ____

Provider Mailing Address______________________________ Phone______________________

City __________________________________ State __________ Zip Code _________________

Provider Email ____

Dates of Service	Child's Name (1 child per invoice)	Hours of Service	Pay Rate
_______________	_____________________________	________________	___________
_______________	_____________________________	________________	___________
_______________	_____________________________	________________	___________
_______________	_____________________________	________________	___________
_______________	_____________________________	________________	___________
		________________ Total Hours	___________ Total Pay

I/we certify that the information provided above is true and accurate to the best of my ability and prior to release of reimbursement I/we may be contacted to verify or provide additional information on the reimbursement claim.

Signature of Parent _______________________________________ Date: ___________

Signature of Provider _______________________________________ Date: ___________

Return this invoice to Idaho Federation of Families for processing and payment

June 2017