



ADOPTION RESPITE BILLING FORM

Date: _____

Adoptive Parents Names: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (Day): _____ Phone Number (Home): _____

Email Address: _____

Name of Person Providing Respite: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (Day): _____ Phone Number (Home): _____

Is Provider an adult (age 18 or older)? _____

Adopted Children for whom respite is being provided:

Name	Medicaid ID #	Age	Male/Female
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Dates Requesting Respite: Beginning: _____ Time: _____
Ending: _____ Time: _____

Number of Days Respite Completed : _____

I certify that the above Respite Services were provided during the time stated above:

Signature of Adoptive Parent: _____ **Date:** _____

Signature of Respite Provider: _____ **Date:** _____

AFTER RESPITE SERVICES HAVE BEEN PROVIDED, THE ADOPTIVE PARENT SHOULD KEEP PAGE 3 FOR YOUR RECORDS AND MAIL PAGES 1 AND 2 TO:

Iowa Foster & Adoptive Parents Association

6864 N.E. 14th Street, Suite 5

Ankeny, Iowa 50023

515-289-4567 (Ext 165) or 1-800-277-8145 (Ext 165) or Fax: 515-289-2080