Matrisza Alvarez –Director of Youth & Family Services
United Cerebral Palsy
3058 Dauphin Square Connector, Mobile, AL 36607
251-479-4900

Service Report

UCP Respite Program

ID#: _____ (office use only)

This form MUST BE RETURNED in order for reimbursement to be received.

Client Name:_____

Date Service Provided: _____

Hours Worked: _____X Rate per hour: _____= Amount: _____

Name of Selected Caregiver: _____ Phone: _____
(UCP reserves the right to contact this individual)

Make check payable to (Parent/Guardian): _____

Phone: _____

Address: _____

City: _____, AL Zip:_____
(Please make sure information is correct. Check will be made out to parent/guardian and mailed to above address. **Please allow 4-6 weeks for the check to be processed after Service Report and Respite Care Programs Survey have been received**. Parent/Guardian will be responsible for paying selected caregiver.)

We confirm that services were provided as stated above for respite care.

_____ _____
Parent/Guardian Signature Selected Caregiver Signature

Comments:

Entered_____
Copied_____