

**OPWDD REGION 1 FAMILY REIMBURSEMENT  
RESPITE VERIFICATION FORM**

\* This form must be signed by the respite provider and the parent/family member where indicated to be eligible for reimbursement. **PLEASE COMPLETE ALL AREAS IN FULL FOR FORM TO BE ACCEPTED**  
 \* All respite providers **must be 14 years of age or older**  
 \* If respite provider is a family member, he/she must maintain a residence **outside of the individual's home.**

1 NAME OF INDIVIDUAL WITH DISABILITY

---

1a DATE OF BIRTH 1b TABS NO.

---

2. NAME OF PARENT/GUARDIAN

---

2a ADDRESS 2b TELEPHONE AND EMAIL

---

3. RESPITE PROVIDER: 3a. RELATIONSHIP:

---

3b. RESPITE PROVIDER'S ADDRESS 3c. RESPITE PROVIDER'S TELEPHONE AND EMAIL

Date Service Provided mm/dd/yy	Time In	Time Out	Number of Hours	Rate Paid Per Hour	Total Amount Paid Per Day	Provider's Initials

Total Hours (this page): Total amount of Request for Reimbursement (this page):

4. Does this respite provider also work for an agency to provide HCBS Waiver In-Home Hourly Respite for your child?  
 Yes  No

\* If so, please note that Family Reimbursement cannot be used to supplement the hourly respite rate of pay and therefore the hours cannot be duplicated.

**PLEASE SEE NEXT PAGE FOR REQUIRED SIGNATURES AND INFORMATION**

Agencies will conduct random spot checks for respite applications;  
respite providers may be contacted to verify hours and payment.

*In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.*

I HAVE READ THE STATEMENT ABOVE AND CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

Respite Providers Signature:

Date Completed:

Parent/Guardian Signature:

Date Completed:

**2019 Respite Verification Form**