Family Support Services
Respite Reimbursement Log

Name of Individual with Disability: _____ Date Submitted: _____

Amount Approved: $_____

Date	Staff Name	# of Hours	Pay Rate	Amount Paid	Staff Signature	Parent Signature

Total Monies Used $_____

Name of family member to whom the reimbursement check should be written:

Name: _____
Address: _____
City, State & Zip: _____
Phone Number: _____

Please Submit To: Catholic Charities Disabilities Services
Family Reimbursement Program – Attention: Amie Anderson
1 Park Place, Suite 200
Albany, NY 12205