Special Needs Respite Grant Respite Log

Name of Individual with Disability:_____

There is no set rate for Special Needs Respite. Families will agree upon the rate along with the Respite Provider they hire. Families are required to keep track of the time by the hour and make payment arrangements with the provider.

*Options for use of Respite funds:

A. Increasing Utilization of existing Waiver Respite funds by supplementing the current pay rate.
B. Providing an additional Respite Staff person (2:1 staffing).
C. Employing an FSS Respite provider at an increased rate.

***Please see reverse side of this log for a more detailed explanation of options for use of Respite funds.**

Date	Name of Respite Provider (Please print)	#of Respite hours provided	Pay Rate per hour	Amount paid or owed	Note which Option Respite was used (See above A,B,C)	Respite Provider's Signature	Parent Signature

Total # of Special Needs Respite Hours Provided:_____

Total Money paid or owed: _____

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

Name: _____

Address: _____

City, State & Zip: _____

Phone Number: _____

Please Submit To: **Catholic Charities Disabilities Services**
Special Needs Respite - Attention: Jessica Pakatar
1 Park Place, Suite 200
Albany, NY 12205

Date Log Mailed to CCDS:_____ **Date Log Received by CCDS:**_____