

**DELAWARE LIFESPAN RESPITE CARE NETWORK
INVOICE FOR SERVICES PROVIDED
9/1/13 – 8/31/14**

FOR DLRCN USE ONLY	
Date Received:	_____
Application number:	_____
Date sent to BO:	_____
Hours Paid by DLRCN:	_____
Funds Remaining:	_____
Approved:	_____ 61400-300-418-212

All funds must be used and invoices submitted by August 31st, 2014.

Make extra copies of blank invoices to keep on hand. Invoice must be signed by the caregiver and the provider after care is completed. Make copies of completed invoice, if desired, prior to mailing/hand-delivering original to the *Delaware Lifespan Respite Care Network; 61 Corporate Circle, New Castle, DE 19720-2439.*

****Important: Please print clearly. If information is not readable, it may result in delay of payment. ****

Information about you and the care recipient(s)	Please fill in all information requested
Your Name:	Amy Johnson
Your Daytime Telephone #	302-999-9999
Dates of Care:	Nov. 3 – Nov 5.
Hours of Care:	3:00 PM on Nov. 3 until 5:00 PM on Nov. 5
1 st Care Recipient's Name and Age:	Michael Johnson, 87 years
2 nd Care Recipient's Name and Age:	
Full Cost of Care:	\$ 400.00
Amount to Be Paid*	\$ 400.00

Information about the respite care provider	Please fill in all information requested
Care Provider Name:	Delaware In-Home Care
Type of Care (check one)	<input type="checkbox"/> Facility/center <input type="checkbox"/> Camp <input type="checkbox"/> Family child care business <input checked="" type="checkbox"/> In-home agency <input type="checkbox"/> Family member or friend <input type="checkbox"/> Other:
Provider Telephone #	302-555-5555

Provider: I certify that I provided care to the person(s) listed for the hours shown. In signing this invoice, I certify that I meet the *Delaware Lifespan Respite Care Network* requirements (see application), and that the information given by me is correct.

Provider Signature Amy Smith

I hereby certify that the information listed on this invoice is correct and meets the requirements of the **Delaware Lifespan Respite Care Network** as noted on the application form.

I accept responsibility for payment of services rendered if they are not covered by my **Delaware Lifespan Respite Care Network** grant.

Your Signature Amy Johnson

*Amount to be paid is based on award amount, amount of money remaining in caregiver's account, and any other guidelines set by the *Delaware Lifespan Respite Care Network*.

By participating in the *Delaware Lifespan Respite Care Network* program, the caregiver and respite care provider agree that the *Delaware Lifespan Respite Care Network* will not have any liability, direct or indirect, for the actions of any particular provider or any adverse consequences that may arise in connection with the use of the *Delaware Lifespan Respite Care Network* program.

To receive payment, provide the following information:

Send payment to: Delaware In-Home Care

SSN of person receiving payment: _____

EIN of provider agency receiving payment: 12-3456789

Direct Deposit: _____ OR send to address below:

Street address: 123 Main St.

City: Wilmington

State: DE Zip: 19805