FOR DLRCN USE ONLY
Date Received: _____
Application number: _____
Date sent to BO: _____
Hours Paid by DLRCN: _____
Funds Remaining: _____
Approved:_____61400-300-418-212

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

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:	Jane Doe
Your Daytime Telephone #	302-999-9999
Dates of Care:	Dec. 18, 2013 Jan. 3, 2014 Jan. 15, 2014
Hours of Care:	Dec 18: 5 hours Jan 3: 4 hours Jan 15: 8 hours
1st Care Recipient's Name and Age:	John Doe, 8 years
2nd Care Recipient's Name and Age:	
Full Cost of Care:	$ 100.00
Amount to Be Paid*	$ 100.00

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 Jane Doe

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.

Information about the respite care provider	*Please fill in all information requested*
Care Provider Name:	Mary Smith
Type of Care *(check one)*	_____Facility/center _____Camp _____Family child care business _____In-home agency __X__Family member or friend _____Other:
Provider Telephone #	302-444-4444

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 Mary Smith

Note to caregiver: *If the provider is a friend, relative, or independent contractor, the payment must be sent to you as reimbursement. If you use a licensed home health agency, licensed PASA, respite program, adult day program, or assisted living facility, you can either 1) pay the provider and have the payment sent to you as reimbursement, or 2) have the payment sent directly to the provider. If you choose Option 2, please include a copy of the provider's invoice along with this Invoice Form.*

To receive payment, provide the following information:

Send payment to: Jane Doe

SSN of person receiving payment: 111-11-1111 (Jane's SSN)

EIN of provider agency receiving payment: _____

Direct Deposit: ___X___ OR send to address below:

Street address:

City:

State: Zip: