

COMMUNITY BRIDGES

70 Pembroke Road, Concord, NH 03301
Tel (603) 225-4153 Fax (603) 225-0376

FOR OFFICE USE ONLY

Account # _____

Authorized Signature _____

FAMILY REIMBURSEMENT REQUEST VOUCHER

Respite Support for _____
(First Name **AND** Last Name of individual receiving supports)

(Parent or Guardian's Signature)

Date Respite Provided	Time Respite Began	Time Respite Ended	Total # of Hours	Hourly/ Daily Rate	Amount Paid by Family	PRINT FULL NAME OF PROVIDER Voucher will be returned if this section is not completed.

Total Amount Paid by Family

Are you satisfied with respite and its ability to meet your needs? Yes No If no, please explain:

Community Bridges **reimburses** parents/guardians directly. Parents/guardians are responsible for paying their providers at the time respite is provided.

Please fill in the parent/guardian name and address where we will mail the check.

Name: _____ Mailing Street Address: _____
Town: _____ State: _____ Zip Code: _____
Telephone #: _____ Date Submitted: _____

Is this a new address? Check here: ***Check here if you need more forms sent to you:***

ATTENTION

It is important that the information reported on this form is **extremely accurate**. Respite reimbursements are paid out of **Federal funds**; vouchers may be subject to **Medicaid audits**. ****Only list dates and times that you actually paid someone to provide support.** Please note, **You** may be required to file a **1099-misc form** for monies **over \$600.00** paid to one provider. **You** may be required to withhold and pay employment taxes if a provider was paid **\$1700.00** or more in one year. These limits can and do change. **Please refer to IRS Publication 926 and IRS Publication "A Guide to Information Returns."**

PLEASE SUBMIT WHITE COPY TO COMMUNITY BRIDGES – KEEP YELLOW COPY FOR YOUR RECORDS