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

FOR OFFICE USE ONLY

Account #_____

Staff Initials _____

FAMILY REIMBURSEMENT REQUEST VOUCHER

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

Respite Provider Full Name _____

Provider Address & Phone No. _____

Date Respite Provided	Time Respite Began	Time Respite Ended	Total # of Hours	Hourly/ Daily Rate	Amount Paid by Family	PROVIDER SIGNATURE Required for each date to attest that respite was provided and payment was received

Total Amount Paid by Family to this provider ☐

Parent/Guardian Signature: _____
to attest that respite was provided and provider was paid

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 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 ***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. **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 **$2000.00** or more in one year. These limits do change. ***Please refer to IRS Publication 926 and IRS Publication "A Guide to Information Returns."***

PLEASE SUBMIT WHITE COPY TO COMMUNITY BRIDGES – FAMILY/PROVIDER KEEP YELLOW COPY