COMMUNITY BRIDGES
162 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 0.00

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."***