



Creative Support for People
with Developmental Disabilities

Family Support Services Reimbursement Expense Log

This form **MUST BE** complete and signed by the family/guardian in order to receive reimbursement for services allocated.

Name of Person Served: _____ SS#: _____

Check Request Payable to:
Name: _____ Address: _____
Phone number: _____ City/Zip: _____

Respite Provider Log

This is to be completed for reimbursement for Respite Services

Date of Service	Start Time	End Time	Negotiated Rate of Pay	Total Hours	Amount Owed
					\$
					\$
					\$
					\$
					\$
					\$
					\$
				Total Due	\$

Respite Provider Signature: _____ Date: _____
Address: _____ City/Zip _____ Phone #: _____

Check Request Payable to:
Name: _____ Address: _____
Phone Number: _____ City/Zip: _____

Family Statement of Expense

This is to be completed for reimbursement for all services except Respite

Type of service being reimbursed	Name of family member receiving services	Date received	Amount owed
			\$
			\$
			\$
			\$
		Total Due	\$

Certification: I hereby certify to the best of my knowledge that the above information is correct. Our family will maintain copies of receipts as specified by Envision and our Family Support Plan/Individual Family Support Plan. Receipts for items/services and supports of over \$60.00 are attached to this statement.

Parent/Guardian Signature

Date

Family Support Services Manager

Date

1050 37th Street / P.O. Box 200069
Evans, Colorado 80620
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Fax 970.330.2261 / www.envisionco.org