RESPITE REIMBURSEMENT REQUEST

Check AM **or** PM in the arrival and departure time area. The Respite provider will be responsible for submitting original within 7 days of service to the Therapeutic Family Care Treatment Manager at one of the addresses below.

YBGR/CBS
TFC Program
5237 Hwy 89 South, Suite 1
Livingston, MT 59047
(406) 222-6490

YBGR/CBS
TFC Program
3212 1st Ave. South
Billings, MT 59101
(406) 245-2751

PROVIDER NAME _____

ADDRESS: _____

_____

CLIENT NAME(S): _____

ZIPPER POUCH ACCOMPANIED THE YOUTH TO RESPIT: ____YES ____NO

Date of Arrival	Time of Arrival		Date of Departure	Time of Departure		TOTAL HOURS
_____	☐am ☐pm		_____	☐am ☐pm		_____

Please check appropriately:

Emergency Respite ☐ Prescheduled Respite ☐

_____ _____
Respite Provider Signature Date

_____ _____
Treatment Parent Signature Date
(If Applicable)

For Office Use Only:

Date:

Check Amount:

Approved By: