HARTWOOD FOUNDATION, INC
RESPITE SUBSIDY PROGRAM
3702 PENDER DRIVE, SUITE 410 ◊ FAIRFAX, VA 22030 ◊ Tel # (703) 273-0939 ◊ Fax (703) 273 - 6807
respitesubsidy@hartwoodfoundation.com

RESPITE REIMBURSEMENT REQUEST

Level of Service: □ Level 1 □ Level 2 □ Level 3 □ Medically Fragile

Special Assistance: □ Advance Request □ Follow-Up Receipt for Advanced Payment □ Professional Nursing Service
(for Pre-Qualified Applicants Only)

Authorization # _____ Authorization Date: _____ Authorized by: □ Email or □ Phone

Individual Name: _____ Parent/Guardian Name: _____

Full Mailing Address: _____Telephone # _____

Provider Name	Respite Date	Begin In	Respite Date	End Out	Total Hours	Family Home?	Provider Home?	Actual Amount Paid to the Provider	Date Paid	Provider Signature	Parent/Guardian Signature

- REQUEST MUST BE SUBMITTED WITHIN 10 DAYS OF SERVICE DELIVERY
- COPY OF INVOICE REQUIRED FOR PROFESSIONAL NURSING SERVICES
- BE SURE TO COMPLETE PROVIDER INFORMATION ON THE BOTTOM OF THIS FORM

***FOR OFFICE USE ONLY*:**

HFI Rate of Pay/Hour _____ Total Hours _____ Total Reimbursement/Hour _____

HFI Rate of Pay/Day _____ Total Days _____ Total Reimbursement/Day _____

Authorized by: _____

BUDGETED HOURS THIS QUARTER: _____

Total # of Hours Used This Quarter _____

Total # of Hours Reimbursed This Quarter: _____

Date Check Processed: _____

Check # _____ Initials: _____

CLAIM DENIED
NOT SUBMITTED WITHIN 10 DAYS ____
EXCEEDS AUTHORIZED EXPENSE ____
NOT AUTHORIZED IN ADVANCE _____

PROVIDER(S) INFORMATION:

FULL NAME: _____

FULL ADDRESS: _____

PHONE NUMBER: _____

IS PROVIDER LISTED WITH HARTWOOD FOUNDATION, INC.? YES____ NO ____

WOULD HE/SHE LIKE TO BE LISTED WITH HFI, PLEASE CHECK THIS BOX: □

PROVIDER(S) INFORMATION:

FULL NAME: _____

FULL ADDRESS: _____

PHONE NUMBER: _____

IS PROVIDER LISTED WITH HARTWOOD FOUNDATION, INC.? YES____ NO ____

WOULD HE/SHE LIKE TO BE LISTED WITH HFI, PLEASE CHECK THIS BOX: □