WCDHS RESPITE REQUEST PAYMENT AUTHORIZATION

USE ONE FORM FOR EACH CHILD

Respite Provider Name: _____
Address: _____

_____

Child's Name: _____
Dates Respite Provided: _____
Number of Nights
(Overnight Respite Only): _____
Number of Hours
(Non-overnight Respite Only): _____

I certify that the information provided is true and correct. The cost represents services as approved by Winnebago County Department of Human Services.

_____ _____
Respite Provider Signature Date

_____ _____
Foster Parent/Parent Signature Date

Please submit completed form to:

Attn: Placement Resource Team
Winnebago County Dept of Human Services
220 Washington Avenue
P.O. Box 2187
Oshkosh WI 54903-2187

Or fax to 920-236-1222

OFFICE USE ONLY:

Number of Days to be Paid _____

Rate Per Day _____

TOTAL _____

_____
Respite Coordinator's Signature

☐ Respite entered in eWiSACWIS