WCDHS Respite Request Payment Authorization

*****USE ONE FORM FOR EACH CHILD*****

Respite Provider Name: _____

Address: _____

_____

Child's Name: _____

Dates Respite Provided: _____

Number of Nights: _____

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

_____ _____

Respite Provider Date

_____ _____

Foster Parent/Parent Date

Please submit completed form to:
Attn: Resource Team
Winnebago County Dept of Human Services
PO 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 Date

☐ Respite entered in eWiSACWIS