



## RESPITE CARE PROVIDER PAYMENT FORM

Complete and Return to:

ASGA Take a Break

580 Grant Street, Akron OH 44311

Scan and E-mail form to: [Info@autismakron.org](mailto:Info@autismakron.org)

Payment will be sent directly to the respite care provider within 30 days.

### **RESPITE CARE PROVIDER INFORMATION**

Name of Respite Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### **FAMILY INFORMATION**

Name of Parent/Guardian: \_\_\_\_\_

Name of Person with ASD: \_\_\_\_\_ Age: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_ Total Number of Hours: \_\_\_\_\_

*NOTE: ASGA will provide payment of up to \$42 (3 hours at \$14/hour) directly to the respite care provider chosen by the parent/guardian on behalf of the person with ASD. The expectation is that the respite care provider will provide care for all of the children. ASGA does not make any representation as to the respite care provider's qualifications, training, experience, suitability or character. That is the sole responsibility of the parent/guardian to determine the right fit.*

My signature acknowledges that the respite care services were provided as described above and in a manner satisfactory to me.

Signature of Parent/Guardian: \_\_\_\_\_

Signature of Respite Care Provider: \_\_\_\_\_

***Thank you for providing valuable respite care to families living with autism!***