CWS RESPITE SUPPORT SERVICES PROGRAM
RESPITE CARE AGREEMENT AND CLAIM FORM
Health and Human Services Agency

*Please make sure that all information is complete and **please print legibly** before submitting. Missing information will require resubmission.*

Resource Parent Name:	Respite Provider/Payee Name:
Address:	Address:
City: Zip:	City: Zip:
Phone Number:	Phone Number:
Identify how your respite provider has been cleared: ☐ **RFA** ☐ **Licensed Foster Home**	Respite Provider/Payee last 4 digits of SSN or Tax ID number:

CLAIM FOR THE MONTH OF: _____
(Month) (Year)

Session 1

Name of Respite Eligible Child:	Caregiver Relationship to Child:	DOB:	Total Children:

Date In:	Time In:	Date Out:	Time Out:	Total Hours:

OFFICE USE ONLY

Level Of Care:	Regular Rate:	Overtime Rate:	Total Payment:

Session 2

Name of Respite Eligible Child:	Relationship:	DOB:	Total Children:

Date In:	Time In:	Date Out:	Time Out:	Total Hours:

OFFICE USE ONLY

Level Of Care:	Regular Rate:	Overtime Rate:	Total Payment:

Session 3

Name of Respite Eligible Child:	Relationship:	DOB:	Total Children:

Date In:	Time In:	Date Out:	Time Out:	Total Hours:

OFFICE USE ONLY

Level Of Care:	Regular Rate:	Overtime Rate:	Total Payment:

Total Claim Hours		Total Claim Payment	

I acknowledge and understand that payment for the respite provider's services will be made on behalf of the resource parent by the County of San Diego Health and Human Services Agency. ***I adhere to the terms and conditions stated on the back of this agreement and I hereby certify that the information on this agreement/claim form is true and accurate.***

_____ _____
Resource Parent Signature Date Respite Provider Signature Date

_____ _____
Reviewed by Respite Program Assistant Date Respite Program Coordinator Date

HHSA AGREES TO PAY THE RESPITE PROVIDER: For services rendered upon receipt of a properly completed respite claim form, with payment to occur approximately 6 to 8 weeks after claims have been received and approved.

Revised 03/16/2020

CLAIM FORMS:

- Are due no later than 30 calendar days following the month of service.
- Original claim forms must be completed, signed, and submitted after the services have been provided.
- Total respite care hours will not exceed 100 hours per calendar quarter per resource family. For excess respite hours, the family must obtain pre-approval from the program coordinator.
- Unused respite hours do not accumulate month to month.

RESOURCE PARENTS:

- You must have at least one dependent qualified child placed in your home.
- The respite provider cannot live in the same household as the resource parent.
- Respite services may not be used to provide respite services to other families.
- Options or other County-provided respite services may not be used simultaneously with this respite program.
- A resource parent may ***not*** provide respite unless their resource home is RFA approved or a licensed foster home.
- A resource parent may ***not*** provide overnight respite if they are at capacity.
- A resource parent may ***not*** provide respite if they have a child specific RFA approval.
- A resource parent may ***not*** provide respite if their RFA approval is in “inactive” status.

RESPITE PROVIDERS:

- Must be foster home licensed or RFA approved.
- May not provide respite if their RFA approval is on HOLD or "Inactive" status.
- Must have up to date IRS Tax Form W-9 and CA Franchise Tax Board Form 590 on file (The address on these forms must match the address on the respite claim form).

MAIL YOUR CLAIM FORMS TO:

County of San Diego
Health and Human Services Agency
CWS Respite Services Program
8965 Balboa Avenue
San Diego, CA 92123

Revised 03/16/2020