|  |  |
| --- | --- |
|  | MISSOURI DEPARMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **RESPITE PROVIDER EVALUATION/PAYMENT INVOICE** |

|  |  |  |  |
| --- | --- | --- | --- |
| Respite forms must be given to a worker for processing within 5 working days of receiving respite services. Each section must be completed before submitting for payment. Refer to policy 4.17.7 for rate amounts. | | | |
| **Section I.** |  | | |
| Resource Parent Name(s): |  | | |
| Resource Parent's DVN: |  | | |
| Number of Available Respite units prior to current usage: | |  |  |
| **(If you are uncertain, please contact a worker prior to utilizing respite services.)** | | | |
| **The case manager was notified prior to this respite placement:** Yes  No | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Children's Names | | | | Medicaid Number | | | | | Level of Care | | | | | Case Manager Name and Agency | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | | |  | | | | | | | | | | | | |
| **Section II** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date Respite Began: | |  | | | | | | Date Respite Ended: | | | | | | | |  | | | |  | | | | | | |
| Time Respite Began: | |  | | | | | | Time Respite Ended: | | | | | | | |  | | | |  | | | | | | |
| Total Respite Units to be paid: | | | | | | | | | | | | @ | | | | |  | | @ | |  |  |
| Total Respite Units for Above Standard Subsidy: | | | | | | | | | | | | @ | | | | |  | | @ | |  |  | | | |  |
| Respite Provider's Name: | | |  | | | | | | | | | | | | DVN: | | |  | | | | | | | | |
| Respite Provider's Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Section III Evaluation of Respite Care** *(To be completed by resource parent)* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **The home was:** | | | | | | | | | | | **The Caregiver was:** | | | | | | | | | | | | | | | |
| Clean | | | | | | | | | | | Easily accessible | | | | | | | | | | | | | | | |
| Child Friendly  Safe  Ample Space | | | | | | | | | | | Friendly/Attentive | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Cooperative | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Organized | | | | | | | | | | | | | | | |
| Other, Explain: | | | | | | | | | | | Other, Explain: | | | | | | | | | | | | | | | |
| Please comment on the respite provider. Your experience is valuable: (Attach additional sheets if necessary) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Resource Parent’s Worker: | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Office Address of Worker: | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  |  | | |  | | |  | | | | | | | | | | |  |  | |
| Signature of Resource Parent | | | | |  | Date | | |  | | | Signature of Respite Provider | | | | | | | | | | |  | Date | |