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|  | MISSOURI DEPARMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **RESPITE PROVIDER PAYMENT INVOICE FOR ADOPTIVE/GUARDIANSHIP PARENTS** |

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| Respite forms must be given to a worker for processing within 6 months of receiving respite services. Each section must be completed before submitting for payment. | |
| **Section I.** |  |
| AD/LG Parent Name(s): |  |
| AD/LG Parent's DVN: |  |
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| Children's Names | | | Medicaid Number | | | Level of Care | | Case Manager Name and Agency | | | | | | | | |
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| **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: | |  | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | |
| Amount Paid to Respite Provider $ | | | |  | | | | | | | OR | | | | | |
| Check Box if Reimbursement to Contracted Respite Provider Is Needed   |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | | Signature of Respite Provider (Required) |  | Date | | Signature of Adoptive/Guardianship Parent (Required) |  | Date | | | | | | | | | | | | | | | | | |