DELAWARE LIFESPAN RESPITE NETWORK
INVOICE FOR SERVICES PROVIDED

FOR DLRN USE ONLY
Month/Year Submitted: _____
Total Hours: _____
Approved:_____61000-300-418-208

Make extra copies of blank invoices to keep on hand. Invoice must be signed by the caregiver and the provider after care is completed**.** Make three copies of completed invoice: mail/hand-deliver one copy to the ***Delaware Lifespan Respite Network*** program, caregiver keeps one copy, and provider keeps one copy. Submit invoices as you use respite care. For care that takes place toward the end of the year, you must submit invoices no later than January 10.

****Important: Please print clearly. If information is not readable, it may result in delay of payment.****

Information about you and the care recipient(s)	*Please fill in all information requested*
Caregiver Name	
Caregiver Daytime Telephone #	
Dates of Care	
Hours of Care	
1st Care Recipient's Name and Age	
2nd Care Recipient's Name and Age	
Full Cost of Care	$
Amount to Be Paid*	$

Caregiver: I hereby certify that the information listed on this invoice is correct, and that the use of this care is respite-related and short-term. I also certify that this provider meets the following requirements:

- is 19 years of age or older
- has provided a Social Security # or EIN
- is not my spouse/partner or the care recipient's parent
- is not the care recipient's regular care provider, unless being used for additional hours beyond the normal care schedule

I accept responsibility for payment of services rendered if they are not covered by my **Delaware Lifespan Respite Network** account.

Caregiver Signature_____

Amount to be paid is based on award amount, amount of money remaining in caregiver's account, and any other guidelines set by the **Delaware Lifespan Respite Network.*

By participating in the *Delaware Lifespan Respite Network* program, the caregiver and respite care provider agree that the *Delaware Lifespan Respite Network* will not have any liability, direct or indirect, for the actions of any particular provider or any adverse consequences that may arise in connection with the use of the *Delaware Lifespan Respite Network* program.

Information about the respite care provider	*Please fill in all information requested*
Provider Name	
Type of Care *(check one)*	_____Facility/center _____Family child care business _____In-home agency _____Family member or friend _____Other:
Provider Telephone #	
Social Security # or EIN	

Provider: I certify that I provided care to the person(s) listed for the hours shown. In signing this invoice, I certify that I meet the ***Delaware Lifespan Respite Network*** requirements (see bottom of first column), and that the information given by me is correct.

Provider Signature_____

Note to caregiver: *If the provider is a friend, relative, or independent contractor, the payment must be sent to you as reimbursement. If you use a licensed home health agency, licensed PASA, respite program, adult day program, or assisted living facility, you can either 1) pay the provider and have the payment sent to you as reimbursement, or 2) have the payment sent directly to the provider. If you choose Option 2, please include a copy of the provider's invoice along with this Invoice Form. Below, indicate whether the check is to be sent to you or to the provider.*

_____Send payment to me _____Send payment to provider

Make check payable to:

Street address:

City:

State: Zip:

___***check here if this is a new address***

Mail or hand-deliver voucher to:
Delaware Lifespan Respite Network
61 Corporate Circle, New Castle DE 19720-2439
302-324-4444

Rev 1-10