Care Giver Reimbursement Form

Relief Care Reimbursement Form MUST be provided to Homes of Hope within 30 days of care given or reimbursement is not guaranteed.

Foster/Adopt Parent Name _____ Signature _____

To be filled in by Relief Care Worker

Relief Care Worker's Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone Number _____

Date(s) of Relief Care _____ Hours of Relief Care _____

I was paid $_____ on_____ for relief care by_____
(Date paid)

(**circle** whether the child is foster or adopted)

Foster/Adopt _____ Age _____
Foster/Adopt _____ Age _____
Foster/Adopt _____ Age _____
Foster/Adopt _____ Age _____
Foster/Adopt _____ Age _____
Foster/Adopt _____ Age _____

Signature _____ Date _____

Return reimbursement form in one of the following ways:
EMAIL LaNae at: clientservices@homesofhopeIDWA.org
MAIL OR DROP OFF at 818 17th Ave. Lewiston, ID
QUESTIONS? Email clientservices@homesofhopeIDWA.org or call 208-413-6770

For office personnel ONLY
Active foster child verified? _____Yes ____No Amount Granted $_____
Grant Title_____ Date Sent_____ Check #_____

Request Denied _____Yes _____No If declined, why? _____