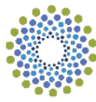

RCAW
Respite Care Association of Wisconsin

Caregiver Respite Grant Program
Step 3: Grant Report

Primary Caregiver Name: ____ Date: ____________

Care Recipient Name and DOB: ____________________________________ _______/______/______

RCAW is not the employer of the respite care provider, and this form is not an employment timesheet. The CRGP Grant Report is supporting documentation for RCAW to provide funding to the primary caregiver to receive respite care. RCAW will not pay individual workers directly.

SCHEDULE OF RESPITE SERVICES PROVIDED						
Date Service Provided	**Time Started**	**Time Ended**	**Total Hours/Days**	**Unit Rate**	**Total Dollar Amount**	**Office Use Only**

Acknowledgment

By signing below, I attest there was provided respite care for the primary caregiver and care recipient for the dates and times mentioned above. Furthermore, by signing below, I agree to hold harmless and indemnify RCAW and any of its' representatives for any damages or liabilities it incurs arising from this agreement.

The total amount requested for respite care services rendered = $_______________

See the next page for direct payment to be made by RCAW to agencies.

____
Respite Provider Name/Company (Printed)

____ _________________________
Respite Provider Signature Date

____ _________________________
Family Caregiver Signature Date

Submit completed form to @ info@respitecarewi.org

Caregiver Respite Grant Program

Step 3: Grant Report for Agencies, Facilities, and Organizations

Only complete this page if RCAW is to pay the respite care agency directly.

If you have selected for the care recipient to stay in a facility-based environment, RCAW will pay them directly. They must complete the *Grant Report for Agencies, Facilities, and Organizations* and attach an invoice for services rendered.

TO BE COMPLETED BY RESPITE CARE PROVIDER AGENCY:

Agency Name:

____

Address:

____

City, State, ZIP:

____

SSN or FEI Number: ______________________________________

Phone: ____________________________

Total to be paid $_____________________________

Acknowledgment

By signing below, I attest there was provided respite care for the primary caregiver and care recipient for the dates and times mentioned above. Furthermore, by signing below, I agree to hold harmless and indemnify RCAW and any of its' representatives for any damages or liabilities it incurs arising from this agreement.

____

Respite Provider Name/Company (Printed)

____ ___________________________

Respite Provider Agency Representative Signature Date

____ ___________________________

Primary Caregiver Signature Date

Submit completed form to info@respitecarewi.org