OTTAWA/ PEORIA TRIBE

CAREGIVER RESPITE CARE VOUCHER

DATE ISSUED: _____ VOUCHER# _____

BALANCE REMAINING: _____

CAREGIVER: _____

ADRESS: _____ City _____

State _____ Zip _____

Care provided for: _____

ADDRESS: _____ City: _____

State: _____ Zip: _____

Respite Care Provider

CHECKS WILL BE SENT TO:

Name: _____

Address: _____

City ,State, Zip _____

Phone _____

Datas Respite Care Provided:

Date: _____ Hours: _____ Date: _____ Hours: _____

Date: _____ Hours: _____ Date: _____ Hours: _____

Date: _____ Hours: _____ Date: _____ Hours: _____

Date: _____ Hours: _____ Date: _____ Hours: _____

Amount charged per hour: $9.00 Total Care Hours: _____ =

$_____

Please sign, mail or bring in this completed form to

LINDA PLOTT

CAREGIVER PROGRAM

OTTAWA TRIBE OF OK.

P.O.BOX 110

MIAMI, OKLAHOMA 74355

Date: _____ **Signatures:**

Respite Provider: _____

Caregiver: _____

Caregiver Director: _____