

ASSOCIATION FOR INDIVIDUAL DEVELOPMENT  
Respite Reimbursement Request Form

Name of client and Social Security # receiving respite care:	
Make check payable to: (name) Parent/Guardian Name:	
Mail check to: Address City, State, Zip	

**RESPITE SERVICE:**

Respite Dates	Name	Pay Rate	Hours	TOTAL PAY	Family Contribution	Assn. Payment
<b>TOTALS</b>						

Please Return To: Association For Individual Development  
309 W. New Indian Trail Court  
Aurora, IL 60506  
Attn: Respite Casemanager

worked at the above stated rate. I request to be reimbursed by AID for its portion as determined in the application. I am responsible for the designated family contribution and for payment that exceeds the authorization amount. I understand that the provider is not an employee of AID with respect to the services described above, and that I may be legally responsible for payment of employer taxes if the worker is my employee.

**Form must be submitted within 30 days.**

\_\_\_\_\_  
Caregiver Signature Date

\_\_\_\_\_  
Parent Signature Date

\_\_\_\_\_  
AID Approval Date

New: 09/96 Revision: 05/05, 06/04, 06/03, 8/00  
I verify that the above person or organization provided respite to my son/daughter, and agree to pay the provider for the total time