

PARTNERS IN POLICYMAKING®

RESPITE CARE/CHILD CARE/PCA REIMBURSEMENT EXPENSE REPORT

This form must be signed by the PCA/respite care/child care provider or the parent/guardian where indicated. Once completed, please attach to your **Participant Reimbursement Request** (include all receipts) and mail to GTS Educational Events, 2233 University Avenue W, Suite 150, St. Paul, MN 55114

Date	Time-In/Time out	Total Number Of Hours	Rate Paid Per Hour	Total Amount Paid

TOTAL NUMBER OF HOURS: _____

TOTAL AMOUNT TO BE REIMBURSED: \$ _____

SERVICE PROVIDER'S SIGNATURE (PCA/Child Care/Respite Care Provider):

_____ DATE: _____

PARTNER'S SIGNATURE:

_____ DATE: _____

**This form must accompany any request for
Respite Care/Child Care/PCA reimbursement on the Participant Reimbursement Request!**