



**2008-2009 Alabama Respite
Voucher Enrollment Form**

Mail to: Linda Lamberth, Alabama Respite
1521 E 9th Street
Anniston, Alabama 36207

PLEASE PRINT CLEARLY

Name of parent/guardian: _____

Street or Post Office Box Address: _____

City: _____ AL Zip: _____ County: _____

Home Phone: _() _____ Work Phone: _____ Cell : _____

E Mail Address: _____

Tell us about the person you care for:

Their Name _____ Date of Birth _____ Age _____

MALE FEMALE (circle one) Your relationship to Person you care for: _____

What is their diagnosis/disability: _____ **(REQUIRED: Attach Proof of
Diagnosis – See the enrollment procedures for information about what documents are
acceptable and eligible.)**

Circle any of the following that apply to you. In the past year, I received respite care from the following agencies/organizations:

MEDICAID Waiver UCP HEARTS/Children's Trust Fund Respite

AAA (Alabama Cares) Alabama Head Injury Foundation

OTHER AGENCY PROGRAM (LIST): _____

If the person you care for participates in a day program, please print the name of the day program you use: _____

PLEASE READ AND INITIAL EACH BLANK BELOW:

_____ I understand that I must mail this form (Voucher Respite Enrollment Form), proof of disability/diagnosis and demographic data form to complete voucher respite enrollment process.

_____ I understand that after I am approved for respite, I will be responsible for selecting and training a trustworthy respite provider. (Respite provider must be at least 18 years old and not reside in the home.) Neither Alabama Respite nor UCP will be held responsible for any actions taken by my selected respite provider.

_____ I understand, that in order to receive reimbursement for respite services, my service report form must be received in the Alabama Respite office no later than 5 days after the expiration date stated on the service report form. I understand that I must allow 30 days for a reimbursement check to be mailed to my address that I provided on this enrollment form.

_____ I agree to the above conditions and my funds will be used **ONLY** for respite care.

Signature: _____ Date: _____