



**UCP/MR  
Voucher Respite  
Enrollment Form  
(New Respite Service)**



Date: \_\_\_\_\_

Name of Person You Care For: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ MALE FEMALE (circle one)

Diagnosis: \_\_\_\_\_ **(REQUIRED: Attach Proof of Diagnosis – this may be a copy of records from a medical facility or another service agency. )**

Name of parent/guardian: \_\_\_\_\_

Relationship to Person you care for: \_\_\_\_\_

Address: \_\_\_\_\_

E Mail Address: \_\_\_\_\_

City: \_\_\_\_\_ AL Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Please read and initial each line below:

\_\_\_\_ I understand that I must call for approval of voucher at the beginning of each quarter.  
**(Voucher expires at the end of each quarter.)**

\_\_\_\_ I understand that service reports must be mailed to Alabama Respite before expiration date for the specific quarter in order to receive payment. (Please allow 7-10 business days for check to be mailed.)

\_\_\_\_ I understand that it is my responsibility to select and train 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 the selected respite provider.

\_\_\_\_ I understand that I must mail this form (**Voucher Respite Enrollment Form**), **Demographic Data** form, and **proof of disability/diagnosis** to complete application process.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_