Wildwood Programs Family Support Services
Respite Reimbursement Log

Child's Name: _____ Date Submitted: _____

Staff Name: _____

Staff Address: _____ Staff Phone#: _____

_____

Date	Name of Staff	# of Hours	Rate of Pay	Amt. Paid	Signature of Staff
	Please total hours =				

Total Amount: $_____

Reimbursement to: **Parent Name_____**
Address_____
City, State, Zip_____
Telephone # _____

I _____ affirm that the above information is complete and accurate.
(parent signature)

Please return by email, fax, or mail;

HGiorgianni@wildwoodprograms.org **Fax: 518-640-3307**

Wildwood Programs, 1190 Troy-Schenectady Rd., Latham, NY 12110
Attn: Heather Giorgianni