COMPLETE THIS FORM AND RETURN IF YOU ARE USING
A PRIVATE RESPITE CARE PROVIDER

Private Respite Care Provider Agreement

I,____________________________, agree to provide respite care services as described below for
(Printed Name of Person Providing Respite Care)

______________________________, through this agreement with ______________________________
(Printed Name of Person Getting Care) (Printed Name of Family Caregiver)

at the rate of $___________ per _____________.
(Dollar Amount) (Hour/Day/Week)

I understand that the Family Caregiver named above and I will keep the Record of Respite Services to show the days and hours that respite care is provided by me, as well as the amounts paid to me. These vouchers will be submitted to the Southwestern Commission Area Agency on Aging for reimbursement to the Family Caregiver.

I further understand that funding available to the Family Caregiver through this program is limited and is not designed to provide an ongoing means of financial support in getting respite care services for his/her care recipient.

Description of Respite Care Services to be provided: ________________________________

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______________________________	______________________________
Printed Name of Person Providing Respite Care	Printed Name of Family Caregiver
Signature of Person Providing Respite Care	Signature of Family Caregiver
Street Address of Person Providing Respite Care	Street Address of Family Caregiver
Town, State, Zip	Town, State, Zip
Phone Number	Phone Number
Date	Date

For further information, contact Jeanne Mathews at the Southwestern Commission Area Agency on Aging, 828-586-1962, ext. 217.

Mail completed form, along with signed Record of Respite Services to:
Jeanne Mathews – Southwestern Commission Area Agency on Aging – 125 Bonnie Lane – Sylva, NC 28779