MONTHLY REQUEST FOR PAYMENT

Payment request must be received in the office *BEFORE* the 5th of each month

RESOURCE PARENT(S): ______________________ **Month** ________ **Year** ________

Foster Children(s) Name(s):	Start Date This Month	End Date this Month
1		
2		
3		
4		
5		
6		

Respite Provided or Used for the Following Children:	Start Date	End Date	Circle One
1			Provided / Used
2			Provided / Used
3			Provided / Used
4			Provided / Used
5			Provided / Used
6			Provided / Used

Monthly Required Forms Checklist:

	Form	Check if attached
1	Monthly Request For Payment	
2	Medical, Dental & Therapy Appointment (if no appointment(s) put NONE on the form)	
3	Health Provider Contact Form (complete one for each appointment attended)	
4	Clothing Purchased Monthly	
5	Monthly Allowance Report	
6	Medication Adminstration Record (if no medication given put NONE on the form)	
7	Psychotropic Medication Adminstration Record (complete only if ***psychotropic*** medication is given)	

By signing below you are verifying the above information submitted is accurate and complete.

______________________________ Resource Parent Signature

______________________________ Date

For Office Use Only

	Received	Follow Up	Date/Initials		Received	Follow Up	Date/Initials
#1				#5			
#2				#6			
#3				#7			
#4							

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