

**WESTWIND FOSTER FAMILY AGENCY  
INTENSIVE TREATMENT FOSTER CARE PROGRAM**

**RESPITE REIMBURSEMENT**

Child: \_\_\_\_\_ Foster Parent: \_\_\_\_\_

Respite Provider: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Date & Time of Drop-off: \_\_\_\_\_

Date & Time of Pick-up: \_\_\_\_\_

Incidents? Yes No

Describe: \_\_\_\_\_

Fee paid by foster parent for respite: \_\_\_\_\_  
(not to exceed \$65 per 24-hour period or \$130 per 48-hour period)

\_\_\_\_\_  
Signature of Foster Parent

\_\_\_\_\_  
Signature of respite provider  
(acknowledging payment received)

**Completed forms must be submitted within 7 days of service to:**  
Westwind FFA P.O. Box 605, Richmond, CA 94808 or Fax 510-233-2053.

For Office use only:

ASW approval: \_\_\_\_\_