

Participant Reimbursement Request

Weekend Date: _____

Child Care: _____ hours @ \$ _____/hour \$ _____ *

Respite Care: _____ hours @ \$ _____/hour \$ _____ *

PCA # of hours _____ @ \$ _____/hour \$ _____ *

(The attached form must be completed and signed by the provider.)

Mileage # of miles _____ @ \$.50/mile \$ _____

TOTAL AMOUNT OWED: \$ _____

***Total of these three (child care, respite care & PCA) amounts
cannot exceed \$190 per weekend.**

Make Check Payable To: _____

(Note: Check must be payable to Partners Class Member, not provider!)

Mail Check To: _____

Signature of Claimant (Partner): _____

Please return this form and signed provider form (if claiming PCA/child care, respite)
within two weeks of class session to:

Government Training Services
Attn: Carol Schoeneck
2233 University Avenue West, Suite 150
St. Paul, MN 55114

If you have questions, please call 651-222-7409. Payment will be processed within 30 days of receipt of this completed form.

**PAYMENT CANNOT BE PROCESSED WITHOUT SIGNATURE OF
CLAIMANT AND SIGNATURE OF PROVIDER(S)!**

PARTNERS IN POLICYMAKING®

RESPIRE CARE/CHILD CARE/PCA REIMBURSEMENT EXPENSE REPORT

This form must be signed by the PCA/respire care/child care provider or the parent/guardian where indicated. Once completed, please attach to your **Participant Reimbursement Request** (include all receipts) and mail to Government Training Services, 2233 University Avenue W, Suite 150, St. Paul, MN 55114

Date	Time-In/Time out	Total Number Of Hours	Rate Paid Per Hour	Total Amount Paid

TOTAL NUMBER OF HOURS: _____

TOTAL AMOUNT TO BE REIMBURSED: \$ _____

SERVICE PROVIDER'S SIGNATURE (PCA/Child Care/Respire Care Provider):

DATE: _____

PARTNER'S SIGNATURE: _____ DATE: _____

**This form must accompany any request for
Respite Care/Child Care/PCA reimbursement on the Participant Reimbursement Request!**