

**NATIONAL CENTER FOR CHILDREN AND FAMILIES
GREENLEAF TREATMENT FOSTER CARE PROGRAM
RESPIRE CARE VERIFICATION FORM**

Name of Respite Provider: _____

Name of Foster Care Provider: _____

Name of Foster Child: _____

Dates in Respite Care: _____

Number of Nights in Respite Care: _____

Please note that pay periods close on the 15th and 30/31st days of each month. Please be sure you submit this form on or before these dates in order to receive pay in a timely manner.

Please complete the following:

1. What activities did the child engage in during his/her visit?
2. Describe eating and sleeping patterns during his/her stay.
3. How was the child's mood/attitude?
4. Were there any problems? If so, how did you handle them?
5. Any other comments – please use the back of the page if needed.

Respite Provider Signature: _____

Thank you for completing this form. Please mail, fax, e-mail or drop off this form for each respite care service you provide, by the 15th or 30/31st of each month to Program Director, TFC.

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