

Return to: Attention: Angie Blakeman Athens County Children Services P.O. Box 1046 Athens, OH 45701	Foster Parent: _____ Month/Year: _____ Name of Child(ren): _____ _____ Caseworker: _____
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RESPITE PAYMENT FOR CARE

<u>RATE</u> \$30.00 per night

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Number of days _____ X \$30.00 = \$ _____

RESPITE MILEAGE

Date	Child(ren)- first and last names	Destination	Purpose	Miles

Mileage Requested: _____ miles @ .555 cents/mile=
\$ _____

TOTAL AMOUNT REQUESTED (Per Diem and Mileage) = \$ _____

 Foster Parent Signature Date

Agency Approval: _____

Type of Respite: Foster Child Cluster Non Custody

