OTTAWA/PEORIA TRIBE
CAREGIVER RESPITE CARE VOUCHER

DATE ISSUED: __________________ VOUCHER# __________________

BALANCE REMAINING: __________________

CAREGIVER: __________________

ADDRESS: __________________ City: __________________
State: __________________ Zip: __________________

Care provided for: __________________

ADDRESS: __________________ City: __________________
State: __________________ Zip: __________________

Dates Respite Care Provided:
Date: ___________ Hours: ________ Date: ___________ Hours: ________
Date: ___________ Hours: ________ Date: ___________ Hours: ________
Date: ___________ Hours: ________ Date: ___________ Hours: ________
Date: ___________ Hours: ________ Date: ___________ Hours: ________
Amount charged per hour: $9.00 Total Care Hours: ________ = $ ________

Please sign, mail or bring in this completed form to

Date: ___________ Signatures: __________________

Respite Provider: __________________

Caregiver: __________________

Caregiver Director: __________________

LINDA PLOTT
CAREGIVER PROGRAM
OTTAWA TRIBE OF OK.
P.O.BOX 110
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