LIFESPAN RESPITE CARE GRANT RESPITE CARE PROVIDER SERVICE LOG

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 546 (8-2025)

Clear Fields

FOR OFFICE USE ONLY

Approved for Payment ☐ Yes ☐ No
Date Approved
Total Reimbursement Approved $

Complete the entire form and submit within 60 days from the first day of service.

SECTION 1. PROVIDER INFORMATION

Name	Telephone Number	Month and Year of Billing Period	
Address	City	State	ZIP Code

SECTION 2. CAREGIVER/CARE RECIPIENT INFORMATION

Caregiver Name	Care Recipient Name

Insert the day, the times of service, and number of hours or days of respite service that were provided to this caregiver/care recipient.

Date	Start Time	End Time	Number of Hours or Days of Respite Service

Number of Hours	x	Established Hourly Rate	=	Total Hourly Amount	**(Per day hourly reimbursement total cannot exceed the allowable maximum daily rate)**
Number of Days	x	Established Daily Rate	=	Total Daily Amount	
Total Amount Requested					

SECTION 3. CERTIFICATION AND AGREEMENT OF AGENCY PROVIDERS

I certify that the foregoing information is true, accurate, and complete. Services herein charged were actually rendered and were rendered under the conditions specified. I understand that payment and satisfaction of this claim will be from federal funds, and accept, as payment in full, the amounts paid, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws.

☐ **By checking this box and typing my name below, I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I further agree to receive, obtain, and/or submit documents and information relating to the Lifespan Respite Care Grant Service electronically. I understand I may request a paper version of this and other documents and I have the right to withdraw my consent to electronic delivery.**

Provider Signature	Date

Submit within 60 days from the first day of service:

Adult and Aging Services
1237 W Divide Ave Suite 6
Bismarck ND 58501

Telephone: (855) 462-5465
Fax: (701) 328-8744
carechoice@nd.gov

Email Completed Form Here
(by clicking this button, the form is emailed to carechoice@nd.gov)