

Sheridan Patterson Center- Foster Parent Invoice and Monthly Log

Board of Care (BOC) Daily Rate: \$ _____

Month of Invoice: _____

Difficulty of Care Daily Rate: \$ _____

Foster Parent's Name: _____

Foster Child's Name: _____

Age: _____ DOB: _____

Respite Taken: YES ___ NO ___ Family Member: YES ___ NO ___ Respite Dates: _____

Name of Respite Family: _____

Respite Provided: YES ___ NO ___ Family Member: YES ___ NO ___ Respite Dates: _____

Name of Child/Children You Provided Respite For: _____ Age _____

_____ Age _____

Please Complete:

SERVICE AREAS:	YES	NO	# of days in placement at foster parent home only	# of days in month respite (family member)	# of days in month respite (non-family member or other foster parent)	Comments	Total Days
Foster Child Placement							
less # of days your foster child in respite							()
Add # of days you provided respite for another foster child							
SUBTOTAL:							
Incidents (Behavior Problems), Crisis, etc.							

Foster Parent(s) Signature: _____ Amount Owed: _____

Therapist Signature: _____

Please Complete

Make Check Payable To: _____

Complete Mailing Address: _____
