



Children's Personal Care Services
Legally Responsible Adult Payment Request
THESE PAYMENTS ARE CONSIDERED TAXABLE INCOME

Date:						
Check Payable to:						
Relationship to Child: (ex. Parent/Guardian)						
Are you a Foster Parent or Shared Living Provider?	☐ Yes	☐ No				
A personal care attendant is unavailable due to significant and recurring barriers.	☐ Yes	☐ No				
I am fully capable to deliver the medically necessary personal care services to the beneficiary.	☐ Yes	☐ No				
Mailing Address:						
Child's Name:						
Personal Care Provided:	Date:	Number of Hours:				
	For ARIS Use Only:					
<table border="1" style="width: 100%;"><tr><td style="width: 20%;">Total Hours:</td><td></td></tr><tr><td>Total Payment:</td><td></td></tr></table>	Total Hours:		Total Payment:			
Total Hours:						
Total Payment:						
Child's Authorized Hours per Week:						
Total Hours Requested:						

DCF Foster Parents & DAIL Shared Living Providers are not eligible to receive this payment.

I (below) certify, under the pains & penalty of perjury, that I have provided direct care to the above-named child for the hours requested on this form and am the authorized to sign this form for the purposes of obtaining payment for said services.

Employer Signature:	Date:	Phone Number:
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