"A field of choices...
Where abilities grow"

CDDO of Butler County

Family Support Summer Care Request

Date: _____ ☐ **Preapproval Request** ☐ **Reimbursement Request**

Applicant Name: _____ Social Security: _____ DOB: _____

Parent/Guardian Name(s): _____

Address: _____

TCM: _____Phone: _____

Name of Care Provider: _____ Age _____

Estimated cost of care for preapproval: Hrs/wk _____ X Rate of Pay_____ = $_____

Time	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Parent/Guardian activity(s)
6:00 AM								
7:00 AM								
8:00 AM								
9:00 AM								
10:00 AM								
11:00 AM								
12:00 PM								
1:00 PM								
2:00 PM								
3:00 PM								
4:00 PM								
5:00 PM								
6:00 PM								
7:00 PM								
8:00 PM								
9:00 PM								

Explanation of Need:

Maximum amount available for FY22 is $3000

Family Support Summer Care

NAME: ____ DOB: ____________________________________

Requested Reimbursement Amount: Hrs/wk __________ X Rate of Pay___________ = $___________

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

By signing this form, I confirm I provided care to the above named individual, in the family home, while the parents were unavailable. I have reviewed this form with the family and they approve the documentation be submitted to the CDDO for review and reimbursement.

Signature of Care Provider____Date________________