TEXAS
Health and Human Services
Children with Special Health Care Needs Services

CHILDREN WITH SPECIAL HEALTH CARE NEEDS SERVICES PROGRAM

Family Support Services Request

Respite Timesheet | FSS Request Packet Form E

Instructions: Timesheets/claims for payment must be submitted monthly, and must document the dates and hours worked. **Do not include dates from more than one month on one timesheet.** Timesheets/claims for payment must be received by the CSHCN Services Program within 95 days of the dates worked. Submit claims via fax at **512-206-3988**, email to **cshcn@hhs.texas.gov**, *or* mail to:

CSHCN Services Program | FSS Claims
Office of Primary and Specialty Health, MC 1938
P.O. Box 149030
Austin, Texas 78714-9030

Client Name: _____ **Client ID:** _____ **Date Submitted:** _____

Provider Name: **Provider ID:** **Hourly Pay Rate:**

Authorization: Respite for period from _____ to _____ approximately _____ hours per month at _____ an hour. Respite hours that exceed the authorized amount, _____ will not be reimbursed. Verify with client's family for remaining respite hours.

Month/year:					
Date	**Time In**	**Time Out**	**Total Hrs**	**Cost/day**	**Comments**
Total:					

I certify that services were delivered during the hours recorded and assigned work tasks were completed. **Provider Signature:** **Date**:	I certify that to the best of my knowledge, the employee has worked the hours recorded and completed the work tasks assigned. **Parent/Guardian/Adult Client Signature:** **Date:**

FOR OFFICE USE ONLY
Authorization Number: **Authorization date:**

For any questions regarding this form, call 800-252-8023.