The Arc
Franklin & Fulton Counties

OFFICE USE ONLY

Supervisors' approval initials: _____

Date: _____ Hours Approved: pay_____bill_____

Mileage Approved: _____ Food Expense: $ _____

Activity Reimbursement: $_____ EVV Verified: _____

Community Reimbursement Approved: $_____

2314 Philadelphia Ave
Chambersburg, Pa 17201
Phone: (717) 264-4390
Fax: (717) 264-4390
www.thearcoffranklinfultoncounties.com

1:2 Respite 15 Service Report

Employee Name: _____ **Date of Service:** _____

Hours of Service: ____:____ am/pm to ____:____am/pm **Total Hours:**_____

Consumer's Name: _____ **Location:** _____

Did you complete personal care items?	**Yes**	**No**
Did you supervise awake time for health and safety?	**Yes**	**No**
Did you supervise sleep time for health and safety?	**Yes**	**No**
Did you go into the community?	**Yes**	**No**

Where did you go? Why did you go there? _____

_____

Service Summary:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My signature below verifies that I received/provided a service on the dates and times listed above or documented corrections below. Further, all of the information in the entirety of this document is true and factual. I understand that payment for these services are from Federal and State funds, and that any false claims, statements, documents, or concealment of material facts may be prosecuted under Federal and State Laws.

Emergency Contact: _____ **Phone Number:** _____

Signature of Employee: _____ **Date:** _____

Signature of Consumer/Guardian:_____ **Date:** _____

EVV notes _____