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: $ _____

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In Home and Community Supports

Staff Name: _____ Date of Service: _____

Hours of Service: _____AM/PM - _____ AM/PM Total Hours: _____

Odometer Start: _____ End: _____ Total Miles: _____ (applicable consumers only)

Consumer's Name: _____Location of services: home or community (circle one)

Time skill started: _____am/pm Ended: _____am/pm **ISP Outcome:** _____

What is the skill the consumer is working on:_____

What did the consumer work on to support the skill/outcome? _____

How did staff support the consumer in learning or maintaining this skill?_____

Describe consumer progress or lack of progress to ISP goal: _____

Time skill started: _____am/pm Ended: _____am/pm **ISP Outcome:** _____

What is the skill the consumer is working on:_____

What did the consumer work on to support the skill/outcome? _____

How did staff support the consumer in learning or maintaining this skill?_____

Describe consumer progress or lack of progress to ISP goal: _____

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 _____