COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING

OPTIONS PROGRAM

Consumer Reimbursement for Personal Care or Home Support Services

Consumer: _____ ☐ **Personal Care** ☐ **Home Support**

Independent Contractor Name: _____

Month/Year _____ **Page** _____/_____

Date	Time In	Time Out	Total Time	Detailed Description Of Services Performed	Cost Per Hour	Total Cost	Contractor Signature

Total Monthly Cost $_____ (Total of all pages)

I certify the individual listed above provided care/services to myself as documented and in accordance to my Care Plan. _____ _____ Consumer Signature Date	(For Office Use Only) _____ _____ Date received Date approved _____ _____ Care Manager Signature Date

Appendix C.2

File Distribution:
- Maintain original at AAA
- Copy to the consumer

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Consumer: _____ Month/ Year _____ Page ____/_____

Date	Time In	Time Out	Total Time	Detailed Description Of Services Performed	Cost Per Hour	Total Cost	Contractor Signature

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