



# Family Aide Service Report

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

[www.thearcoffranklinfultoncounties.com](http://www.thearcoffranklinfultoncounties.com)

Employee Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Hours of Service: \_\_\_\_:\_\_\_\_ am/pm to \_\_\_\_:\_\_\_\_ am/pm Total Hours: \_\_\_\_\_

Consumer's Name: \_\_\_\_\_ Location: \_\_\_\_\_

**FREQUENCY/DURATION:** services may be provided up to four (4 sessions) per month, with a combined total of hours not to exceed 24 hours per month.

Did you provide supervision for relief of the caregiver? Yes No

**SERVICE SUMMARY:** \_\_\_\_\_  
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My signature below verifies that I received/provided a service on the dates and times listed above, as indicated above in the Service Summary section. 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: \_\_\_\_\_