AUTISM FUNDING

PROOF OF SERVICE

FAX: 519-972-8902

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

PARENT'S NAME: ____________________

CHILD'S NAME: ____________________

RESPITE PROVIDER'S NAME: ____________________

FAMILY COORDINATOR: ____________________

PAY PERIOD END DATE ____________________

*****TIMESHEETS ARE DUE EVERY OTHER WEDNESDAY BY 4:00PM*****

					FOR OFFICE USE ONLY	
DATE		# HOURS PROVIDED	INITIALED BY RESPITE PROVIDER	ACTIVITIES	RATE	SVC TYPE
Sun						
Mon						
Tues						
Wed						
Thur						
Fri						
Sat						
Sun						
Mon						
Tues						
Wed						
Thur						
Fri						
Sat						
TOTAL HOURS:						
				TOTAL:	$	

I verify that these services were provided for me. I have been authorized by Family Respite Services to use these services. I am invoicing FRS for the funds which I have paid to my respite provider/caregiver.

Signature of Parent/ Guardian: ____________________ Date: __________

Signature of Respite Provider: ____________________ Date: __________