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.	(For Office Use Only)
____________________ Consumer Signature ________ Date	____________ 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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