

**FAMILY AID/COMMUNITY EXPOSURE
LESS THAN 24 HOUR
BILLING/REPORTING FORM**

Individual: _____

Family Aid Provider: _____

Address: _____

Address: _____

Date of Service: _____

Time Entered: _____

Time Exited: _____

To be filled out by person who provided aid/community exposure time.

Service Provided (Please check one):

In their home _____

In your home _____

Community _____

Please comment on any of the following items:

(Care Provided (Ex: assisted with bath), Goals worked on (Ex: walked for 10 minutes), Choices/Activities offered, Whom interacted with, etc.)

Comments _____

I _____ completed _____ hours of Family Aid/Community Exposure on _____ at
the rate of _____.

Family Aid Provider

Date

Family Living Provider

Date

Program Specialist

Date