



## Arkansas Lifespan Respite Voucher Service Report

This form is to be completed by the Primary Caregiver as documentation of voucher fund utilization. The Primary Caregiver must have the Respite Provider sign for each date of service where voucher funding was used. This form must be submitted, along with the Satisfaction Survey Questionnaire upon full utilization of the voucher award or within 10 calendar days of the award term expiration date. Unused funds must be returned.

Printed Name of Care Recipient _____	Printed Name of Respite Provider _____
Printed Name of Primary Caregiver _____	Respite Provider Address _____
Primary Caregiver Address _____	Respite Provider Phone _____
Primary Caregiver Phone _____	

Respite Provider Signature	Date of Service	Respite Start Time	Respite End Time	# of Hours Used	Rate of Pay	Total
EXAMPLE <i>Jane Doe</i>	7/20/2021	10:00a	2:00p	4.00	\$15.00	\$60.00
<b>TOTAL</b>						

\_\_\_\_\_  
 Primary Caregiver Signature Date  
 With my signature above, I certify that all information on this voucher is correct and I submit this report as justification of how the voucher funding was spent.

<b>FOR INTERNAL USE ONLY</b>  _____ Documentation Reviewed and Accepted- Arkansas Lifespan Respite Grant Manager <span style="float: right;">Date</span>	Award Term	/ / - / /
	Award Amount	
	Vendor #	
	Unused Voucher Balance to be returned (if applicable)	