FAMILY SUPPORT SERVICES

PAYMENT VOUCHER AND EVALUATION REPORT

For questions, inquiries and/or to submit vouchers please contact:

Southern Ohio Council of Governments
P. O. Box 456
Chillicothe, Ohio 45601
Telephone: 740-775-5030
Fax: 740-775-5023

Provider Information

Care given to: ____________________________________ Date(s)___________________________________

Rate ________ Date_____________ Total Hours ________________ Amount $__ __________________
Date_____________ Total Hours ________________ Amount $__ __________________
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Provider Name: ____
Provider Signature: ____

The above services and payments are accurate: Yes _________ No _________

I have received the Brown County Board of Developmental Disabilities Family Support Services Policy 5.06, and I understand my privileges and responsibilities. It is my responsibility to be familiar with this policy and the rules of the Brown County Board of Developmental Disabilities. I understand that I will be directed by them. When using a family selected provider, I assure and assume responsibility that the health and safety needs of the individual receiving respite services have been met and that no liability shall be incurred by the Brown County Board of Developmental Disabilities and Southern Ohio Council of Governments.

Parent/Guardian Signature: ____ Date ______________________
Address ____
____

FOR OFFICE USE ONLY

FSS Obligation ____________________% Family Obligation ____________________%

Amount authorized from FSS $ __________________

Payable to: ____

Authorized by: ____ Date: ____________________

RESPITE QUALITY CONTROL FORM

Parent/Guardian Comments

Were you satisfied with the Provider? Excellent________ Good _________ Fair__________ Poor ___________

Fill Out For In-House Respite	Yes	No	N/A	Comments
1. Service was provided on the dates and times desired				
2. Supervision was adequately provided.				
3. The provider left your home in as good or better condition than when he/she arrived.				
4. Nutritionally balanced meals were prepared.				
5. The care provided was generally good.				
6. I would use this provider again.				

7. Additional comments ____

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Fill Out For Out-Of-House Respite	Yes	No	N/A	Comments
1. Service was provided on the dates and times desired.				
2. There was adequate heating, plumbing, and electrical service to meet the needs of the individual.				
3. There was adequate non-sleeping living space.				
4. Furnishings were safe, appropriate and comfortable and in good repair.				
5. The sleeping room was ventilated or had one outside window; if occupied by a non-ambulatory person, the room was on the first floor and had appropriate furnishings.				
6. The kitchen was clean				
7. The bathroom was in good repair, clean, free from odor, adequately supplied, and had hot and cold running water.				
8. Laundry service was available.				
9. The home was in good repair.				
10. Exits were clear of debris.				
11. Smoke detectors were present.				
12. Nutritionally balanced meals were provided.				
13. All toxic products were stored away from food				
14. Supervision was adequately provided.				

15. Additional comments: ____

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Signature: ______________________________________ Date: ____________________