

# Parents – Direct Services Received

If you have any questions about the collection of this information, you may contact the child's Family Support for Children with Disabilities (FSCD) worker.

- **Complete a separate form for each separate service for each month.**
- **Submit this form along with the individual invoice.**
- **The parent/guardian must sign this form before payment can be made.**

Please select only one of the following to indicate what type of service was provided.

<input type="checkbox"/> Hourly Respite <input type="checkbox"/> 24 Hour Respite – Basic Need <input type="checkbox"/> 24 Hour Respite – High Need <input type="checkbox"/> Community Aide <input type="checkbox"/> Personal Care Aide	<input type="checkbox"/> Specialized Services <input type="checkbox"/> Behavioural Aide <input type="checkbox"/> Developmental Aide <input type="checkbox"/> Homemaking <input type="checkbox"/> Extraordinary Child Care (parents work/school related)
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Child's Name \_\_\_\_\_

SERVICE PROVIDER INFORMATION	
Agency Name: _____	Phone Number: _____

Record of Direct Services Provided:	Month: _____
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Date	Times		Total Hours
	Start	End	

Date	Times		Total Hours
	Start	End	
<b>Monthly Total</b>			▶

**I acknowledge that the above services have been engaged, and approved by myself. They have been provided and I am responsible to pay for them. Subject to prior approval through an Agreement with FSCD, FSCD may reimburse me by paying an agency for these services.**

Parent/Guardian (PRINT NAME) <b>X</b>	Signature of Parent/Guardian <b>X</b>	Date
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