VOUCHER
FAMILY SUPPORT SERVICES PROGRAM

Payable to: _____
(Provider) _____
_____

In the Account of: _____
(Client's Name) _____
_____

SERVICES RENDERED

Respite Care:	**Emergency**	_____	**In-House**	_____	**Hours**	_____
	Planned	_____	**Out-of-House**	_____	**Overnight**	_____

Date(s) of Service: _____

Voucher must be endorsed after services are delivered satisfactorily by the family receiving the services and the Payee (provider). Completed vouchers should be returned to *FAMILY SUPPORT SERVICES PROGRAM, 245 Valley Road, Xenia, Ohio 45385*, for redemption within 7 to 10 days of issuance.

_____ _____
Family Signature **Date**

_____ _____
Payee Signature **Date**

The above-named services have been delivered to my satisfaction.

Quality of Care: **Satisfactory** ☐ **Unsatisfactory** ☐

Comments:_____
_____
_____

For Office Use Only:

FSSP % _____ **Amount Paid**
$8.10 per hour
$109.35 per overnight (13.5 hrs) **$** _____

_____
FSSP Coordinator/Date

Updated: 12/30/2013
Updated: 12/29/2014