

Fiscal Year FY24

**ADULT AUTISM SUPPORT CENTER
FLEX FUNDING REIMBURSEMENT FORM**

Send this form and any receipts to:

Northeast Arc

Adult Autism Support Center

100 Independence Way STE D3

Danvers, MA 01923

Fax: 978-762-3980 (ATTN: AASC)

Unsigned forms cannot be processed

MAKE CHECK PAYABLE TO:

PROVIDER/VENDOR NAME: _____

ADDRESS: _____

CITY/TOWN/ZIP: _____

CONSUMERS NAME: _____

____ RESPITE

____ PURCHASE OF GOODS
(Attach Receipts)

____ PURCHASE OF SERVICE
(Attach Receipts)

FAMILY MEMBER'S SIGNATURE _____ DATE _____

ONLY FILL IN BELOW IF SUBMITTING FOR RESPITE REIMBURSEMENT

RESPITE PROVIDER'S NAME: _____ Phone: _____

RESPITE PROVIDER'S SIGNATURE: _____

Respite Dates:

Times:

Total Hrs. X Rate of Pay:\$ _____

TOTAL AMOUNT PAID TO PROVIDER: \$ _____

Office use only

ACCOUNT BEING CHARGED: 46860-696

DATE RECEIVED: _____ AMOUNT PAID: _____

PROGRAM APPROVAL: _____

FINANCIAL APPROVAL: _____ DATE: _____