Fiscal Year **FY25**

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:* _____