THE ARC OF KONA

HOME & COMMUNITY BASED SERVICES
P. O. BOX 127 ♦ KEALAKEKUA, HI 96750 ♦ PHONE (808) 323-2626 ♦ FAX (808) 323-9444

DIRECT SERVICE PROVIDER RECORD

Participant Name _____ Employee Name _____

Parent/Guardian/Responsible Person _____

Date	Day of Week	Service Hours (e.g. 2pm-7pm) Day Ends at Midnight	Main IP Goal Worked On (e.g. Community Access, Recreation & Leisure, Activity of Daily Living (ADL), etc.)	No. of Hours	Parent/ Guardian/ Responsible Person Initials
				Total:	

"I certify that all hours declared have been delivered as specified."

_____ _____
Direct Service Worker Signature Date

"The Personal Assistant has provided services on the above stated day(s) in a satisfactory manner."

_____ _____
Parent/Guardian/Responsible Person Signature Date

Distribution: White Copy to Administration * Yellow Copy to Parent/Guardian * Pink Copy to Personal Assistant

THIS FORM MUST ACCOMPANY TIME SHEETS TO OBTAIN PAYROLL APPROVAL