(719) 836 – 4295
scofpc@parkco.us

P.O. Box 309
825 Clark St. Suite C
Fairplay, CO 80440

WWW.PARKCOSENIORS.ORG

FOR PCSC USE:

Date Received:
Amount:

Homemaker Program Voucher

Thank you for participating in our In-Home Voucher Program. This valuable service allows Park County seniors 60 years of age or older to receive homemaking assistance maintain their independence and keep their home safe and healthy.

In-Home Services Authorized for Park County Senior Coalition Voucher Payments:

Making and changing beds	Washing clothes, dishes, floors	Vacuuming carpets
Cleaning bathrooms and floors	Emptying trash	Dusting
Light Meal Prep & Putting away groceries	Other light housekeeping	

The senior employer is responsible for selecting and hiring their service provider. Once Homemaker services have been provided, the client must complete the information below/on the back and return this Homemaker Voucher to Park County Senior Coalition, **P.O. Box 309 Fairplay, CO 80440.**

Vouchers must be submitted once services are rendered. Unused hours will not carry over. Client, by signing below, you are acknowledging that the hours submitted for payment are correct. Payment will be made within two weeks of receipt of the voucher.

*****VOUCHER MUST BE SUBMITTED TO PCSC IN THE SAME*****
****MONTH THE WORK WAS DONE.*****

Client name ______________________ Client phone _____________________

Client address ____

Service Type: Homemaker **Number of hours authorized: 5**

The homemaker services will be reimbursed at $20.00 per hour.

The maximum total reimbursement for services performed under this voucher: **$ 100**

I was provided _______ TOTAL hours of Homemaker Services.
Amount of reimbursement requested: $____________

Homemaker Program Voucher

Homemaker(s):

Name: ________________________________ Signature: ______________________
Phone: ________________

Date and hours worked ____
Total hours______

Name: ________________________________ Signature: ______________________
Phone: _______________

Date and hours worked ____
Total hours______

Name: ________________________________ Signature: _____________________
Phone: _______________

Date and hours worked ____
Total hours ______

Client Signature ____ ***Date*** _________________

The Check will be made payable to the client.

Note to Direct Provider and Client: I understand that **the client** employs the Care Provider to do In-Home services and that they are not an employee or contractor of the Pikes Peak Area Agency on Aging, Pikes Peak Area Council of Governments, or Park County Senior Coalition and has not had a background check. It is understood that these agencies will not be held responsible for any injuries or damages that might occur during the time In-Home Care is provided. The Consumer is responsible for any difference not covered by PCSC. By signing you certify that this is a true and accurate record of hours provided.

Direct Provider Signature____________________

Client Signature_______________________