CENTER FOR HUMAN DEVELOPMENT & FAMILY SERVICES INC.

HCBS Flex Funds Report
(Monthly)

Name of Child: _____

Client's card number: _____

Date Received Funds: _____ Amount of Funds: _____

Date Receipts Were Turned In:_____

Date	Type of Service Provided	Time of Service	Transportation	Food	Admissions	Other (explain)
			TOTAL	**TOTAL**	**TOTAL**	**TOTAL**
COMBINED TOTAL						
MONEY RETURNED						

Worker Signature Date

By signing this form, I declare that I am responsible if any of the receipts are missing, are not valid, incorrect, or for any mistakes made on the form. I understand that the package will be returned for revision and there may be delays on card replenishment.