

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
**HEALTH AND SAFETY EQUIPMENT AND SUBSTITUTE CARE
EXPENDITURE LOG**

PROVIDER'S NAME:	ADDRESS:	TIME PERIOD: To: / / From: / /
------------------	----------	-----------------------------------

Names of Residents Receiving SSI or Safety Net:

1. _____ 2. _____ 3. _____ 4. _____

Health and Safety Equipment

DATE OF PURCHASE	LIST EACH ITEM PURCHASED. ATTACH RECEIPTS FOR ITEMS OVER \$25.	AMOUNT
/ /		
/ /		
/ /		
/ /		

Office use: Advanced \$ _____
 Expended \$ _____
 Remaining \$ _____
 To be advanced \$ _____

Substitute Care Record

DATE OF SERVICE	NO. OR HOURS PER DAY	COST PER HOUR OR PER DAY	TOTAL COST
/ /			
/ /			
/ /			
/ /			
TOTAL			

Office use: Advanced \$ _____
 Expended \$ _____
 Remaining \$ _____
 To be advanced \$ _____

I hereby certify that the above account is a true and correct statement of money actually spent by me and that residents were residing in my home when the money was spent.

/ /

PROVIDERS SIGNATURE

DATE

DISTRIBUTION: Original – Submit to local office

Copy – For operator's records