COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING

OPTIONS PROGRAM

CONSUMER REIMBURSEMENT REQUEST

Consumer: _____

Reimbursement Request for _____
Month/Year

List each item separately. Provide a detailed description of each service or item listed. Attach all receipts for purchases or services to this form.

DESCRIPTION OF ITEM or SERVICE	DATE	AMOUNT PAID	STORE, VENDOR, or PROVIDER NAME

TOTAL AMOUNT: _____

I affirm the above expenses were incurred according to services authorized in my Care Plan.

_____ _____
Consumer Signature Date

(For Office Use Only)

_____ _____
Date received Date approved

_____
Care Manager Signature

Appendix C.3
11/02/2026

Form Distribution:
- Maintain original at AAA
- Copy to the consumer