KEYSTONE
AUTISM SERVICES

Adult Community Autism Program (ACAP) Encounter Form

PROVIDER INFORMATION: ______________________________________

Address: ______________________________________

____

Phone: ______________________________________

PARTICIPANT PRINTED NAME ____

SERVICE PROVIDED: ____

Date of Service	Time of Service	ACAP Participant Signature or Initials
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____
_____ / ______ / _______ (MM DD YYYY)	_________ to ________	X____

____ ____________________________________

PROVIDER SIGNATURE **DATE**