The Arc Of East Central Iowa

Respite (Non-HCBS/UW Funded) Service Documentation

Consumer's Legal Name: ____ **Date of Birth:** _ _ / _ _ / _ _
(include nicknames used in summary)

Date of Service: _ _ / _ _ / _ _ **Start Time*:** _ _ : _ _ **End Time*:** _ _ : _ _ **# of Siblings Present :** _____

Type of Funding: (circle one): Private Pay County Other: ______________________________________

Location of Service (check all that apply – if visiting more than one location, document when and where in summary):

☐ Consumer's Home ☐ Community (list site i.e. Lindale Mall): ______________________________________

Approximate Activity Length (ex: 30 min, 1 hr)	**Summary of Respite Service:** Must be in complete sentences and remain objective. ***(i.e. What did consumer do? How did consumer respond? What did staff do?)*** To be completed at the end of the respite session or while consumer is sleeping.
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Continue on back if more room is needed. ***DSP & Primary Caregiver/Consumer must complete & sign back.***

Consumer's Legal Name:______________________________ **Date of Birth:** _ _ / _ _ / _ _
(include nicknames used in summary)

A) Were there any injury, illness, or safety issues during the service that required an incident/seizure report:
☐ Yes *(complete & submit incident report)* ☐ No

B) Are there any additional notes, concerns or issues to communicate: ☐ Yes (document below) ☐ No

C) Home Information (Information for Primary Caregiver that is not working – *Complete every section*)
Primary Caregiver Name: ______________________ Contact/Emergency #: (_ _ _) _ _ _ - _ _ _ _
Destination:______________________

Direct Service Provider (DSP) Verification: *Did the DSP have access to Care Plan* (i.e. ELP): ☐ **Yes** ☐ **No***
***If no, explain**: ______________________
Full Legal Name (*Print*): ______________________ DSP ID # ________
Full Legal Name (*Signature*): ______________________ Date ________

Primary Caregiver/Person Responsible for Consumer:
Did the DSP complete documentation and provide a summary of the service? (check one) ☐ **Yes** ☐ **No**
Is the DSP responsible for dispensing/observing medications/procedures? (check one) ☐ **Yes**** ☐ **No**
** if yes, complete a medication log
Signature of Person Responsible for Consumer______________________ **Date** ________

Completed service notes must be turned in on the 1st & 16th each month to the Arc at:
680 2nd Street SE, Suite 200 • Cedar Rapids, IA 52401
Phone: 319-365-0487 • Fax: 319-365-9938

Office Use Only
Office QA by: ________ **Date:**________
Other QA by: ________ **Date:** ________
See Discussion Log: ❑ Consumer ❑ DSP