

# RESPITE SERVICES DOCUMENTATION FORM

CONSUMER NAME: \_\_\_\_\_

CONSUMER'S CASE #: \_\_\_\_\_

WEEK OF: \_\_\_\_\_

(One form per week Sunday through Saturday)

<b>DAY</b>	<b>DATE</b>	<b>START TIME</b>	<b>END TIME</b>	<b>TOTAL HOURS Respite Care Provided (15 minute units)</b> <i>Do not include any time spent providing Home Help Services funded by DHS</i>
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
<b>TOTAL HOURS RESPITE CARE PROVIDED</b>				

I certify the amount of respite written above on the days indicated have been provided.

\_\_\_\_\_  
**RESPITE CARE PROVIDER NAME**  
 (Please Print)

\_\_\_\_\_  
**SIGNATURE** **DATE**

\_\_\_\_\_  
**FAMILY MEMBER NAME/GUARDIAN**  
 (Please Print)

\_\_\_\_\_  
**SIGNATURE** **DATE**

\_\_\_\_\_  
**CONTRACT PROVIDER AGENCY**  
 (Please Print)

\_\_\_\_\_  
**SIGNATURE** **DATE**

\*\*\*Respite Service Documentation Form must be handed in weekly to Contract Provider\*\*\*

**INSTRUCTIONS FOR COMPLETING  
PATHWAYS RESPITE SERVICES DOCUMENTATION FORM**

Respite Care Providers are responsible for completing this form on each day that the consumer receives respite. All documentation for one week must be recorded on the same form. The week starting with Sunday and ending with Saturday. (ONLY ONE WEEK PER FORM – SUNDAY THROUGH SATURDAY)

Please print on this form and use only blue or black ink. **No white-out, if you make an error cross it out and initial it.**

- ✓ Complete the following:
- ✓ Consumer Name: First and last name;
- ✓ Consumer Case Number: Pathways assigned case number
- ✓ Week of : One week per form - Sunday through Saturday (mm/dd/year – mm/dd/year)
  
- ✓ Date: mm/date/yyyy (12/01/2010)
- ✓ Start Time: example 10:00 am (must indicate am or pm) **Do not use Military Time**
- ✓ End Time: example 11:15 am (must indicate am or pm) **Do not use Military Time**
- ✓ Total Hours of Respite Care provided (do not include any time spent providing Home Help Services funded by DHS):
  - Example One (no home help services provided): Respite provided from 10:00 a.m. to 1:15 a.m., Total hours of Respite provided would be 1.15 (must be in 15 minute units)
  - Example Two (home help services provided): Respite provided from 12 a.m. to 12 a.m. (24 hours), during this time 5 hours of home help services are provided, Total hours of Respite Care provided would be 19 hours.

Respite is to be provided as written in each consumer’s Individual Plan of Service (IPOS). Write the start time and the end time of each respite support that was provided in the designated box for each day – **this must be in 15 minute increments (example: 1:00 pm, 1:15 pm, 1:30 pm, 1:45 pm)**. The total number of hours must be **in 15 minute increments only** and recorded daily.

If you provide respite services for more than one period of time on the same day then you need to record each period of time separately. (Example: 9 am – 10 am & 3 pm – 4 pm).

**If you are providing respite to more than one consumer at the same time (siblings), each consumer needs to have a completed respite form with the exact hours respite is being provided.**

example:      Consumer 1    1/1/10                      start time 10 am- stop time 1 pm, total hours 3  
                  Consumer 2    1/1/10                      start time 10 am- stop time 1 pm, total hours 3

**Respite Care Provider:**

The Direct Respite Care Provider must print their name and then sign this form.

**Family Member /Guardian:**

A family member / guardian must print their name and then sign this form.

**Contract Provider Agency:**

The Contract Provider Agency must print the name of the Agency and then the Contract Provider Agency / Designee must sign this form.

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