

**Barry County Community Mental Health Authority
Independent Respite Staff Documentation
DATE**

Consumer Name 1 _____ Start Time 3 _____ Case Number 5 _____
Date of Service 2 _____ Stop Time 4 _____ CSM/SC 6 _____

Respite Goal: 7

Please provide a brief summary of what occurred or was provided:

8

Staff Signature 9 _____ **Date** 10 _____

Consumer Name _____ Start Time _____ Case Number _____
Date of Service _____ Stop Time _____ CSM/SC _____

Respite Goal:

Please provide a brief summary of what occurred or was provided:

Staff Signature _____ **Date** _____

Consumer Name _____ Start Time _____ Case Number _____
Date of Service _____ Stop Time _____ CSM/SC _____

Respite Goal:

Please provide a brief summary of what occurred or was provided:

Staff Signature _____ **Date** _____