Butler County DD Informal Respite Care Level I Documentation Sheet

Name:	Month:
Medicaid #	Year:
Contract Provider #	Page 1 of
Service Period:	
Provider:	

Frequency/Duration:
_____Units Daily
_____Units Weekly
_____Units Monthly
_____ Units Per Year

Family member/Limited Provider
Responsibilities:_____(Date)
Rights of People w/ Disabilities: _____(Date)
Incidents Adversely Affect Health and Safety & Behavior Supports: _____(Date)
Things You Need to Know About Me: _____(Date)
*The above forms should be completed by the parent/guardian and signed by the parent/guardian and provider **annually**. The provider should maintain a copy of these forms.

Day of the Month:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Informal Respite **Time In:** **Time Out:**																															
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Group size if other than 1:1																															
Units (15 min = 1 unit):																															

SIGNATURE/ TITLE	INITIALS	SIGNATURE/ TITLE	INITIALS
Revised			

My initials on the Document sheet and the corresponding signature/ title above signify that I have supported ____ as outlined in ___ISP

Location: These services took place at _____