



Respite Service Report

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Employee Name: _____ Date of Service: _____

Hours of Service: ____:____ am/pm to ____:____ am/pm Total Hours: _____

Start Odometer: _____ End Odometer: _____ Miles: _____ Staff Expenses: _____

Respite Service Definition: provided to supervise and support individuals living in private homes on a short-term basis due to the absence or need for relief of those persons normally providing care. **24 hour respite is provided for periods of more than 16.25 hours. Service are based on available funding. (change effective 9/4/2017)**

Consumer's Name: _____ Phone Number: _____

Address: _____

FREQUENCY/DURATION: _____

OUTCOME: _____

SERVICE SUMMARY: _____

PROGRESS/NO PROGRESS: _____

FOLLOW UP: _____

My signature below verifies that I received/provided a service on the dates and times listed above, as indicated above in the Service Summary section. I understand that payment for these services are from Federal and State funds, and that any false claims, statements, documents, or concealment of material facts may be prosecuted under Federal and State Laws.

Emergency Contact: _____ Phone Number: _____

Signature of Employee: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____