



Base Respite Service Report

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Employee Name: _____ Date of Service: _____

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

Consumer's Name: _____ Location: _____

Did you complete personal care items?	Yes	No
Did you supervise awake time for health and safety?	Yes	No
Did you supervise sleep time for health and safety?	Yes	No
Did you go into the community?	Yes	No

Where did you go? Why did you go there? _____

Service Summary:

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 Consumer/Guardian: _____ Date: _____

Office Use Only - Reviewed date: _____ Reimbursement: _____
Supervisory Staff signature _____