

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

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

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 _____

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