

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

Consumer Name \_\_\_\_\_  
Date of Service \_\_\_\_\_

Start Time \_\_\_\_\_  
Stop Time \_\_\_\_\_

Case Number \_\_\_\_\_  
CSM/SC \_\_\_\_\_

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

**Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Consumer Name \_\_\_\_\_  
Date of Service \_\_\_\_\_

Start Time \_\_\_\_\_  
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