

Consumer's Legal Name: _____
(include nicknames used in summary)

Date of Birth: __/__/__

A) Were there any injury, illness, or safety issues during the service that required an incident/seizure report:

Yes (complete & submit incident report) No

B) Are there any additional notes, concerns or issues to communicate: Yes (document below) No

C) Home Information (Information for Primary Caregiver that is not working – Complete every section)

Primary Caregiver Name: _____ Contact/Emergency #: (___) ___ - ___ - ___

Destination: _____

Direct Service Provider (DSP) Verification: <i>Did the DSP have access to Care Plan (i.e. ELP):</i> <input type="checkbox"/> Yes <input type="checkbox"/> No*	
*If no, explain: _____	
Full Legal Name (Print): _____	DSP ID # _____
Full Legal Name (Signature): _____	Date _____
Primary Caregiver/Person Responsible for Consumer:	
<i>Did the DSP complete documentation and provide a summary of the service? (check one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Is the DSP responsible for dispensing/observing medications/procedures? (check one)</i>	<input type="checkbox"/> Yes** <input type="checkbox"/> No
** if yes, complete a medication log	
Signature of Person Responsible for Consumer _____	Date _____

Completed service notes must be turned in on the 1st & 16th each month to the Arc at:
680 2nd Street SE, Suite 200 • Cedar Rapids, IA 52401
Phone: 319-365-0487 • Fax: 319-365-9938

Office Use Only	
Office QA by: _____	Date: _____
Other QA by: _____	Date: _____
See Discussion Log: <input type="checkbox"/> Consumer <input type="checkbox"/> DSP	