Alta Mira Specialized Family Services, Inc.
Respite/Substitute Care Provider
Monthly Progress Notes

Please place a copy of this form in your Toolbook.

Provider Name:	Month/Year:
Participant Name:	Service Coordinator:

1st of Month through the 15th

Location of Services Provided: ☐ Provider Home ☐ Participant's Home ☐ Community

Community Activities	Description (i.e., name of movie, place visited, etc.)
☐ Movie ☐ Recreation (zoo, park, museum) ☐ Shopping ☐ Out to Eat ☐ Other	

At Home Activities	Description
☐ Games ☐ Cooking ☐ Movies/TV ☐ Arts & Crafts/Hands-on Activities ☐ Electronics (computer, video games) ☐ Outside Time ☐ Other	

Personal Care Assistance	Ongoing	
☐ Bathing ☐ Changing ☐ Dressing ☐ Feeding	Are you related to this Participant?	○ Yes ○ No
	Did you assist with medication?	○ Yes ○ No
	Did you observe seizure activity?	○ Yes ○ No
	Did you observe changes in behavior?	○ Yes ○ No
	Were there additional problems/concerns?	○ Yes ○ No

Additional Comments:

Were there any reportable incidents during respite?	○ Yes ○ No
Was an Incident Report completed within 24 hours?	○ Yes ○ No

Provider Signature: _____ Date: _____

Alta Mira Specialized Family Services, Inc.
Respite/Substitute Care Provider
Monthly Progress Notes

Please place a copy of this form in your Toolbook.

Provider Name:	Month/Year:
Participant Name:	Service Coordinator:

16th of Month through the 30th

Location of Services Provided: ☐ Provider Home ☐ Participant's Home ☐ Community

Community Activities	Description (i.e., name of movie, place visited, etc.)
☐ Movie ☐ Recreation (zoo, park, museum) ☐ Shopping ☐ Out to Eat ☐ Other	

At Home Activities	Description
☐ Games ☐ Cooking ☐ Movies/TV ☐ Arts & Crafts/Hands-on Activities ☐ Electronics (computer, video games) ☐ Outside Time ☐ Other	

Personal Care Assistance	Ongoing	
☐ Bathing ☐ Changing ☐ Dressing ☐ Feeding	Are you related to this Participant?	○ Yes ○ No
	Did you assist with medication?	○ Yes ○ No
	Did you observe seizure activity?	○ Yes ○ No
	Did you observe changes in behavior?	○ Yes ○ No
	Were there additional problems/concerns?	○ Yes ○ No

Additional Comments:

Were there any reportable incidents during respite? ○ Yes ○ No
Was an Incident Report completed within 24 hours? ○ Yes ○ No

Provider: _____ Date: _____