THIS FORM MUST BE RETURNED WITHIN 20 DAYS OF THE FIRST SERVICE DELIVERY DATE - BOX #9

RESPITE DOCUMENTATION RECORD - INDIVIDUAL SUMMARY

1. "Hourly Respite" (X) "Free Standing Respite" ( )

2. Agency Name: Nassau Suffolk Services for Autism

3. Consumer Name: _____

4. Medicaid ID #: _____

5. TABS ID #: _____

Respite Specialst Name (Print): _____

6. Program Location: Agency-80 Hauppauge Rd. Commack, NY 11725
Services take place in individuals home or community

7. TABS Program Code: **78260813**

8. Is Consumer HCBS Waiver Enrolled? (X) Yes ( ) No

9 Service Delivery Date	10 Start Time	11 End Time	Parent/Guardian Signature*	12 Respite Specialist Signature	13 Date of Signature		15 Service Delivery Time	16 Billing Units (1 billing unit is 15 minutes)

(Items 9-13 to be completed by Respite Service Staff)

(Items 15 and 16 to be completed by Billing Dept.)

PARENT/GUARDIAN NAME: _____ **DATE:** _____

***VERIFICATION OF RESPITE SERVICE DELIVERY: By signing each day, parent/guardian is attesting that respite service was provided during the hours specified. This verification must be made at the time of service delivery.**

******PLEASE BE SURE THAT YOU ARE SIGNING AND DATING THE SAME DAY THAT SERVICE IS PROVIDED******

*****Please note when printing on line parents & providers are responsible for making their own copies.*****