



Southwest Ohio Council of Governments

Family Support Services Program

1520 Madison Road, Cincinnati, Ohio 45206

phone- (513) 559-6800, fax- (513) 559-6600, TDD (513) 475-0025

Instructions: Please fill out all areas, sign, and return. PLEASE PRINT!

Individual you are providing respite care for: _____

Provider's Information

Social Security Number: _____

Name: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Email Address (if applicable): _____

Terms of Agreement

I understand that if I am selected as a family-selected provider, I will be providing respite services for the _____ family. I agree to accept vouchers, to be redeemed with the Family Support Services Program (FSSP) equal to the FSSP co-payment portion of care. I understand that by State requirements, FSSP has up to 45 days to issue a check after the voucher is received in the FSSP office. The family share of the cost, if any, must be collected by me. FSSP ASSUMES NO LIABILITY FOR PAYING THE FAMILY SHARE OF COSTS, IF ANY. I also agree to allow monitoring of my family-selected respite services and to complete any evaluations necessary to complete this monitoring.

I also understand that if I receive payment for services of \$600.00 or more within a calendar year (January 1-December 31) that a 1099 will be sent to the IRS and I will have to pay taxes on that amount.

Signature

Date

Signature of Parent/Guardian
if respite provider is under 18 years

Date

(over)

[Type text]

Specific Job Information

In-Home Care

Would you provide care in the family's home? Yes No

Would you provide overnight care in the family's home? Yes No

Out-of-Home Care

Are you interested in providing care in your home? Yes No

If so, describe the assets of your home (ie., extra bedroom, fenced yard, etc.)

Education, Training and Experience

College Major/ Technical Training: _____

Workshops/ Training about Disabilities and/or Giving Care: _____

List Other Experience with Providing Care and/or Persons Having Disabilities:

List Any Disabilities You Presently Have Which May Make It Difficult To Perform Certain Tasks (ie., bad back- can't lift): _____

[Type text]

Family Waiver

This form is to be completed by the Individual, the Individual’s Parent, or the Individual’s Guardian if a family-selected respite care provider is being utilized.

Family-Selected Respite Care Provider for _____
(Name of Individual)

The above-named individual is myself / my child / my ward. (Circle the applicable status)
I select the following as a respite care provider for the above-named individual:

Name: _____ Phone Number: _____

By my signature below, I certify that the health & safety needs of myself / my child / my ward (Circle one) will be met and no liability shall be incurred by the Butler, Clermont, or Hamilton County Board of Developmental Disabilities for any act or omission committed by the provider of service that I have chosen or by person(s) acting on behalf of the provider of service that I have chosen. Furthermore, I release, indemnify, and hold harmless the Butler, Clermont, or Hamilton County Board of Developmental Disabilities, and their respective offices, employees, and agents from any suit or other legal proceedings arising from any act or omission committed by the provider of service that I have chosen or by person(s) acting on behalf of the provider of service that I have chosen.

I will provide, or cause to be provided, any training that may be needed for any person or persons I have chosen to work with me / my child / my ward (Circle one). If I deem a background check necessary, I will be responsible for assuring that a criminal background check is conducted on the provider that I have chosen to provide respite care services and any person(s) acting on behalf of the provider of service that I have chosen.

I will assure that the provider of service and any person(s) acting on behalf of the provider will be given a copy of, and will read and understand, the Rights of Person with Developmental Disabilities in Ohio Revised Code Section 5123.62.

I will assure that the provider of service and any persons(s) acting on behalf of the provider will acknowledge the obligation by law to report major unusual incidents, as defined in Rule 5123.2-17-02 of the Ohio Administrative Code, to the Office of Incident Review of the County Board of DD, and/or to the appropriate local law enforcement agency, as outlined in Ohio Revised Code Section 5123.61. I acknowledge that I have been given a copy of, and have read, Ohio Revised Code Section 5123.61 and Rule 5123:2-17-02 of the Ohio Administrative Code. I will assure that the provider of service and any persons(s) acting on behalf of the provider will be given, and will read, Ohio Revised Code Section 5123:61 and Rule 5123:2-17-02 of the Ohio Administrative Code.

Signature of Individual / Parent / Guardian

Date

Please sign, date and return this form to:
SWOCOG - Family Support Services Program
1520 Madison Road
Cincinnati, Ohio 45206