FAMILY SUPPORT SERVICES RESPITE CARE PROGRAM

NON-CERTIFIED PROVIDER FORM

We/I ______________________________ have selected ________________________________ to
(Parent/Guardian Name) (Respite Provider Name)

Provide respite care for: ____
(Consumer/Individual Name)

We/I further understand that ____________________________________ will be providing care only to
(Respite Provider Name)

our family.

He/she has the necessary skills needed to provide for the health and safety of my/our children, in lieu of the forty hours of respite care training. The Sandusky County Board of DD is not responsible for the health and safety of __________________________________ while in the care
(Consumer/Individual Name)
of the non-certified provider.

Caregiver's Name: ____

Address: ____

Social Security Number: ____

Effective for services rendered: 07/01/17 through 6/30/18 (Fiscal Year 2018)

Parent/Guardian ____

Date ____

The Sandusky County Board of Developmental Disabilities does not discriminate in provision of services or employment because of handicap, race, color, creed, national origin, sex or age.

FAMILY SUPPORT SERVICES RESPITE CARE PROGRAM

ASSURANCE FORM

____ hereby assures the Sandusky County Board of
(Parent/Guardian Name)

Developmental Disabilities that ____ shall provide for
(Respite Provider Name)

The health and safety of my family member, ____________________________ while he/she is in respite care.
(Consumer/Individual Name)

The Sandusky County Board of DD is not responsible for the health and safety of ___________________________
(Consumer/Individual Name)

while in the care of the non-certified provider.

Effective for Services Rendered: **7/01/17** through **6/30/18** (**Fiscal Year 2018**)

____________________________	____________________________
Signature of Parent/Guardian	Date
Signature of Superintendent of Sandusky County Board DD	Date
Signature of Family Support Services Coordinator	Date

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