MUSKINGUM COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
FAMILY ASSISTANCE PROGRAM
Contractual Agreement
for Family Selected Respite Care Provider Services

It is agreed that Respite Care Services are private arrangements between my (our) self and the respite care provider. The Muskingum County Board of Developmental Disabilities will not be held responsible or liable for any accident, incident, illness, or injury, which might be construed to adversely affect the health, safety, or welfare of _____.
Care Recipient

I (We) have fully disclosed to the family selected respite care provider all pertinent information concerning any medical conditions and/or behavioral problems. I (We) have provided the family selected respite care provider with an Emergency Medical Consent form so that treatment may be sought in the event of an emergency. I (We) fully acknowledge all responsibility for failure to provide this information.

The Muskingum County Board of Developmental Disabilities will be responsible for 100% of the cost of respite care services, up to the allocation amount provided that prior approval has been received from the Muskingum County Board of DD – Family Assistance Program.

I understand and accept responsibility for the fact that this individual does not meet the training or experience requirements to be a Muskingum County Board of DD certified respite provider. However, I feel this individual will provide a good environment and good care for my family member.

I assume all responsibility that the health, safety, and welfare needs of my family member will be met and that no liability shall be incurred by the Muskingum County Board of DD and/or the family selected respite provider named below.

I would like to use the following person as a family selected respite provider: _____

<u>This section to be completed by the respite care provider:</u>
I understand that as the family selected respite care provider I am required to have a Bureau of Criminal Identification (BCI) background check and the six Database Checks (sex offender, nurse aid registry, offender search, abuser registry, exclusions database, system for award management) completed prior to providing services and receiving payment from Muskingum CBDD FAP. **Please initial here to confirm: _____**

_____ _____
Signature of Parent/Family/Guardian Date

_____ _____
Signature of Respite Care Provider Date

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Respite services have been satisfactorily provided to: _____
Please pay the following respite provider for services provided.

NAME: _____ PHONE: _____

ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

DATES OF WHEN SERVICES WERE PROVIDED: _____

HOURS PROVIDED ON DATES LISTED ABOVE: _____

IN THE AMOUNT OF: $_____ DOLLARS

For services rendered (list kinds of services provided) _____

_____

_____

_____

_____

_____ _____
Family/Individual/Parent's Signature and date Respite Provider Signature and date

This request is in accordance with FAP and respite guidelines set forth. The request is recorded in the person's Individual Services Plan (ISP) to support the person's goals and outcomes.

_____ _____
FAP Coordinator and date SSA Director or Designee and date

Approved:

_____
Superintendent/Business Manager

*Complete this page AFTER services are delivered satisfactorily by the family receiving the services and the provider and send to **Muskingum County Board DD, 655 Zane Street, Zanesville Ohio 43701. Attn: FAP**
*The completed W-9 form must accompany this application. The W-9 is done once per year unless there is a change in the information. The W-9 is submitted prior to BCII form being completed.
*BCII is required to reimburse people providing respite who are not the parent or stand in parent (legal guardian, custodian).