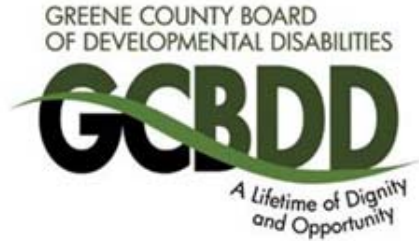


245 N. Valley Road  
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Community Services Director  
J.A. LaRock



Community Services Division  
Behavior Support Services  
Family Support Services  
Investigative Services  
Medicaid Programs  
Public Education  
Service Coordination  
Special Olympics/Recreation

## RELEASE OF LIABILITY

I understand that the individual named below has been certified to provide respite care for my family at my request, and that all training and other routine certification requirements for Respite Caregivers has been waived for the below-named individual. I agree to release and discharge the Family Resource Services program of the Greene County Board of Developmental Disabilities, its agents and employees from any claims or causes of actions arising from any injuries, losses or damages resulting from actions taken or not taken while the below-named individual provides respite for me.

I fully disclosed to the Respite Provider all facts pertinent to the needs and problems of my family member. I understand that I have been charged with the full responsibility for disclosure of all pre-existing conditions of my family member, and hereby acknowledge full responsibility for failure to make such disclosures.

I understand that I will provide \_\_\_\_\_% of the fee for respite to the Respite Provider and agree that the Family Resource Services program will provide reimbursement of \_\_\_\_\_% of the fee for respite services.

The Respite Provider I have chosen is responsible and competent to provide respite services for

\_\_\_\_\_  
(Care Recipient)

I have informed the Respite Provider that he/she will be totally responsible for all Federal, State or Local taxes earned while doing respite services for my family.

\_\_\_\_\_  
Name of Care Recipient

\_\_\_\_\_  
Name of Respite Provider

\_\_\_\_\_  
Name of Responsible Party

\_\_\_\_\_  
Address of Provider

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security # of Provider