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Community Services Director
J.A. LaRock

GREENE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
GCBDD
A Lifetime of Dignity and Opportunity

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**