SOUTHWESTERN OHIO COUNCIL OF GOVERNMENTS (SWOCOG)
Family Support Services Program - GCBDDS
412 S. East Street
Lebanon, OH 45036
Phone (513) 559-6800 Toll free (877) 423-6900 Fax (855) 763-3050
Sandy.Schutte@swocog.org

Instructions: Please fill out all areas, sign, and return. PLEASE PRINT! If your application is illegible, it will delay processing and could result in inaccurate information being used to issue vouchers and payments.

Name of Individual you are providing respite care for: _____

PROVIDER'S INFORMATION

Social Security Number:_____ **MUST ALSO COMPLETE THE ATTACHED W-9**

Name: _____ Birthdate: _____

Street Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Email address: _____

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TERMS OF AGREEMENT

I understand that if I am selected as a family-selected provider, I will be providing respite services for the _____ (name of 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 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.

The family selected provider acknowledges that he/she:

1. is age eighteen or older.
2. shall not provide services to any eligible individual whose needs the provider cannot meet, nor accept payment for services not provided.
3. shall not provide respite services to his/her child or to his/her spouse enrolled in the FSSP.
4. assures that no liability shall be incurred by GCBDDS or FSSP for services provided by this provider or the actions of the provider.
5. does not reside in the same household as the individual receiving services.
6. is not employed by the Greene County Board of Developmental Disabilities Services.
7. must report all incidents of suspected abuse or neglect, and other major unusual incidents to the Department of Safety and Protection for the **child and/or adult age 21 and older** via phone (937) 562-6784 or fax to (937) 562-6539 in accordance with 5123:2-17-02 of the Ohio Administrative Code. (copy provided upon request)
8. must report all incidents of suspected abuse or neglect, and other major unusual incidents to the public children services agency or a municipal or county peace officer in the county in which the child under eighteen years of age or a developmentally disabled, or physically impaired child **under twenty-one years of age** resides or in which the abuse or neglect is occurring or has occurred in accordance with 5120.173 of the Revised Code. (copy provided upon request)

Family Selected Provider Signature _____ Date _____

Signature of Parent/Guardian _____ Date_____

The mission of the Southwestern Ohio Council of Governments is to provide support and solutions to county boards of developmental disabilities through cost-effective shared services that deliver value, satisfaction, and maximization of resources.

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FAMILY WAIVER

This form is to be completed by 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 enrolled in Greene County Board of DDS)**

The above-named individual is my child / my ward. I select the following individual as a respite care provider for the above-named individual:

Name: _____ Phone Number: _____
(Name of Family Selected Provider)

By my signature below, I certify that the health & safety needs of my child / my ward will be met and no liability shall be incurred by the Southwestern Ohio Council of Governments, or the Greene 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 Southwestern Ohio Council of Governments, or Greene 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 my child / my ward.

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.

I will report all incidents of suspected abuse or neglect, and other major unusual incidents must be reported to the Department of Safety and Protection for the **child and/or adult age 21 and older** via phone (937) 562-6784 or fax to (937) 562-6539 in accordance with 5123:2-17-02 of the Ohio Administrative Code. (copy provided upon request).

I will report all incidents of suspected abuse or neglect, and other major unusual incidents to the public children services agency or a municipal or county peace officer in the county in which the child under eighteen years of age or developmentally disabled, or physically impaired **child under twenty-one years of age** resides or in which the abuse or neglect is occurring or has occurred in accordance with 5120.173 of the Revised Code. (copy provided upon request)

_____ _____
Signature Parent / Guardian Date

Please sign, date and return this form to:

SWOCOG - Family Support Services Program
412 S. East Street, Lebanon Ohio 45036

Sandy.Schutte@swocog.org...fax (855)763-3050

Effective January 2019

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