DEFIANCE COUNTY BOARD OF DD

FAMILY SUPPORT SERVICES

ASSURANCE FORM

I/we,_____ hereby assure the Defiance County Board of
(Parent/Guardian Name)

Developmental Disabilities that _____ shall
(Respite Provider)

provide for the health and safety of my/our child, _____ while
(Child/Family Member Name)

he/she is in respite care, and that I/we shall assume all liability for the selection of the provider.

I/we_____, hereby waive my/our rights to have the board
(Parent/Guardian Name)

conduct a background investigation on_____ .
(Respite Provider)

RESPITE PROVIDER'S NAME _____

ADDRESS _____

_____

PHONE_____

SOCIAL SECURITY NUMBER _____

***A copy of the respite provider's social security card must be on file with Family Support Services.**

_____
Signature of Parent/Guardian Date

_____
Signature of Superintendent of Defiance County Board of DD Date

_____
Signature of Family Support Services Coordinator Date

DEFIANCE COUNTY BOARD OF DD

FAMILY SUPPORT SERVICES

This agreement between_____, the Defiance County
(Family Name)

Board of Developmental Disabilities, and _____
(Provider)

guarantees that while_____ is in respite care he/she will continue
(Individual Name)

his/her daily routines in regards to school, sheltered workshop, employment, and habilitative programming. The provider agrees to adhere to the United States Department of Health & Human Services Regulations contained within 45CFR160, 162, and 164 (HIPAA).

_____

Parent Signature Date

_____

Provider Signature Date

_____

Superintendent – Defiance County Board of DD Date

_____

Family Support Services Coordinator Date

This contract, with the above named provider, is valid for one year from the date signed.