Family Support Services
Assurance Form

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

Developmental Disabilities that ______________________________ shall provide for the
(Respite Provider)

health and safety of my/our child, ______________________________ while he/she is in
(Child/Family Member Name)

respite care, and that I/we shall assume liability for the selection of the provider. I/we

______________________________, hereby waive my/our rights to have the Board conduct
(Parent/Guardian Name)

a background investigation on ______________________________.
(Respite Provider)

This agreement between, ______________________________, the Defiance County Board of
(Family Name)

Developmental Disabilities, and ______________________________ guarantees that while
(Provider)

______________________________ is in respite care he/she will continue his/her daily
(Individual Name)

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

Respite Provider Information

Name of Provider: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zipcode: __________

Email: ____________________ Telephone: ____________________

Social Security Number: ______/______/______

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

This contract, with the above-named provider, is valid for One Year from the date signed.

Parent/Guardian Signature: ______________________________ Date: __________

Provider Signature: ______________________________ Date: __________

Superintendent Signature: ______________________________ Date: __________

Family Support Services Signature: ______________________________ Date: __________