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: __________

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