Blanket Respite Provider Selection for Family Support Services

The undersigned hereby agree to the following conditions:

The provider is required to prepare, sign, obtain family verification of services listed from the recipient family and allow the family to maintain a copy to submit for Family Support Services payment directly to the Provider of Respite Service.

The Board will not arrange any payment to the provider without verification by the family that services listed were received.

It is understood that the family receiving services selected the provider signing below and the Auglaize County Board of Developmental Disabilities is in no way endorsing, employing or contracting with the provider.

This assurance will serve as a release of liability. The Auglaize County Board of Developmental Disabilities will not be held responsible for any damages or injuries incurred in connection with services provided by the provider.

Name of Provider (Print): ____

___________________ ____
Date Signature

Name of FSS Requester (Print): _______________________________________

___________________ ____
Date Signature