ASHTABULA COUNTY BOARD OF DD
COMMUNITY SUPPORT SERVICES
500 West Main Street
Geneva, OH 44041
Phone: (440) 466-7110 Fax: (440) 466-7047

FAMILY SUPPORT SERVICES PROGRAM
FAMILY CHOSEN PROVIDER APPLICATION

DATE: _____

PROVIDER NAME_____

First Middle Initial Last (Maiden)

PROVIDER ADDRESS: _____
(Last three addresses)
Street City State Zip How Long

_____
Street City State Zip How Long

_____
Street City State Zip How Long

PROVIDER PHONE:_____

BUSINESS NAME (Occupation) _____

ADDRESS: _____
Street City State Zip

PHONE:_____ PROVIDER'S SOCIAL SECURITY NUMBER _____

Family selected providers please complete this section:

I have been selected by (parent's name) _____

to care for (son/daughter) _____

I understand that the family has a right to waive provider training because of this relationship.

Area of Service: _____ In-Home Respite _____ Out-of-Home Respite

_____
Provider's Signature Date

CONTINUED ON BACK

Ashtabula County Board of DD
Family Support Services
500 West Main Street
Geneva, OH 44041
Phone: (440) 466-7110 Fax: (440) 466-7047

FAMILY SUPPORT SERVICE PROGRAM
WAIVER OF PROVIDER TRAINING FORM

According to the State of Ohio Administrative Code, family selected respite providers need not be county board certified. I understand that by signing this waiver, the family assumes that all health and safety needs of the individual will be met by the family selected provider. **I also understand that liabilities caused by the provider not having been trained will not be met by the Ashtabula County Board of DD.**

NOTE: **All providers are required by law to report abuse/neglect. Ohio Revised Code 5123.61 & 2151.421.**

PARENT/GUARDIAN NAME: _____
(Please Print)

PROVIDER NAME: _____
(Please Print)

DEPENDENT'S NAME: _____
(Please Print)

_____
PARENT GUARDIAN SIGNATURE

_____
DATE