STARK COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

FAMILY MEMBER DELEGATION FORM

FAMILY MEMBER AUTHORIZATION FOR UNLICENSED WORKER TO GIVE OR APPLY PRESCRIBED MEDICATION AND/OR PERFORM OTHER HEALTH CARE TASKS

1. My name is _____. (Please print name of family member. Family member means a parent, sibling, spouse, son, daughter, grandparent, aunt, uncle, cousin or guardian of the individual with mental retardation or a developmental disability. Individual must live with the family member and be dependent upon the family member for support such that if the family member were not present, another living arrangement would have to be made for the individual).

2. I am the _____ (indicate family relationship to individual) of _____ (name of individual with DD). This individual receives funding for in-home care from the Stark County Board of Developmental Disabilities. This individual lives in my home and I am the primary supervisor for the care of this individual.

3. I hereby authorize _____ to give or apply the below described prescribed medication or perform the below described health care task with regard to the individual named in paragraph two and in accordance with the instructions in paragraph four (please print name of unlicensed in-home care worker - worker may be an employee or contract worker for a County Board of DD). Such tasks will be performed in my home or in places incidental to providing care in my home (such as a store, restaurant or place of recreation), including transportation in connection with such care. In-home care does not include care given in a school or a County Board of DD.

4. I understand that I am responsible for the direct supervision of the worker identified in paragraph three, that I am responsible for training the worker, and that I am responsible for giving written instructions to the worker and that such instructions must be in accordance with any instructions from any relevant health care professional. These written instructions are:

Medication/Dosage/Times **Instructions**

_____

_____

_____

_____

_____

_____

_____

Attach additional instruction sheets as necessary. Please sign any additional sheets.

☐ **Please check this box if the person receiving FSS does not take medication(s)**

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5. I understand that I am fully responsible for the health and safety of the individual identified in paragraph two and for ensuring that the worker I have selected in paragraph three acts appropriately and safely. I understand that no other entity that funds or monitors the provision of in-home care (including the County Board of DD, the Ohio Department of DD and any other entity employing the worker) may be held liable for the results of the care provided by the worker. I also understand that the worker is not liable for injury to the individual named in paragraph two unless the worker provides the care in a manner that is not in accordance with the training and instructions I have given to the worker or the worker engages in wanton or reckless misconduct.

6. Upon completion of this form I will send a copy to the County Board of DD named in paragraph two, which board has the responsibility to evaluate the authority given by this form and the authority to revoke such authority and similar future grants of authority subject to my right to file a complaint under Revised Code 5126.06.

_____ Date: _____
Signature of Worker acknowledging receipt of this form and that s/he has received training from the Family Member and understands the written instructions in paragraph four

_____ Date: _____
Signature of Family Member responsible for completing this form