STARK COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

FAMILY SUPPORT SERVICES DISCLAIMER FORM

I, _____,
Parent and/or legal guardian for

_____,
(Hereinafter "Individual") warrant to the Stark County Board of Developmental Disabilities that

_____ Of
(Name of family selected provider)

_____
(Address of family selected provider)

Social Security Number _____,*
(Social Security number of family selected provider)

(hereinafter "Provider") the person who will be providing respite services, is qualified to provide a safe environment and all services necessary to meet the Individual's needs while either in their home or in my home, as set out by the requirements of the Ohio Department of Developmental Disabilities.

I understand that the above named Provider is in no way considered to be an employee or agent of the Stark County Board of DD for any purposes, and I agree to indemnify and hold harmless the Stark County Board of DD for any and all claims that may arise out of the actions or inactions of the Provider.

I have had this Form explained to me and I understand that I am solely responsible for my child and/or ward when they are in the care of the Provider.

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

_____
Parent or Legal Guardian signature

_____
Date

*Social Security Numbers of a private respite care provider are absolutely necessary to assure payment for the provided services by the North East Ohio Network (NEON).

Please complete and return to: Intake/FSS Department – 2950 Whipple Ave NW, Canton, OH 44708