Lucas County Board of Developmental Disabilities

# **2020** Respite Care Voucher

Lucas County Family Support Services Program
Funded by Lucas County Board of Developmental Disabilities

## Family Selected provider is limited to 10 hours per month (Sunday - Saturday), up to $10 per hour.

**The parent/guardian AND the respite care provider must sign the form at the time respite is provided. All family-chosen providers must complete a W-9 Income Tax Form, Master Vendors Form, OPERS Form, and a Responsibility Waiver. All of the requested information must be completed for reimbursement;** if the form is not filled out completely, the form cannot be processed and will be returned to you. **Family Support reserves the right to verify signatures, respite service dates, and times.** A submission of a form for respite services that were not provided could result in the termination of all Family Support Services.

Consumer Name _____

**List each Individual Date and time** _____

_____

_____

Hourly/Daily Rate $ _____ X Total Number of Hours _____ = Total $ _____

Signature of Parent/Guardian _____ Phone _____ Date _____

Signature of Respite Provider _____ Phone _____ Date _____

Please complete the waiver on the reverse side if this is a NEW provider.

Issue Reimbursement Check to:

Name _____
Address _____
City _____ State ____ Zip _____
Phone _____
Email _____

Allow 45 days from date of submission for payment

| OFFICE USE ONLY |
| --- |
| Co-pay _____ |
| Contract # _____ |
| Respite $ Amount _____ |
| ☐ Approved ☐ Denied |
| Date _____ |

Total cost of respite is reimbursed within the current funding limit and in accordance with the family's taxable income level. The funds are not guaranteed and requests need to be **submitted within 30 days of service**, all vouchers **must** be postmarked by November 13, 2020.

**Fax:** 419-380-2610
**Email:** VLambert@lucasdd.org
**Mail to:** Family Support Services
c/o Lucas County Board of Developmental Disabilities
1932 Birchwood
Toledo OH 43614

**Family Selected Provider Responsibility Waiver**

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I agree that the Respite Program and Lucas County Board of Developmental Disabilities will not be construed to adversely affect the health, safety, or welfare of:

_____
Name of Consumer(s)

While in the care of the Respite Care Provider whom I have selected to provide this service:

_____
Print name of Family Selected Provider

_____ _____
Family Selected Provider Signature (may request verification of Provider's Signature) Phone Number

_____
Address City State Zipcode

I waive my right to have a background investigation conducted on the Family Selected Provider.

I will hold harmless from any damages resulting from this service, the Lucas County Board of Developmental Disabilities. I have fully disclosed to the said provider all pertinent facts about my dependent's needs and problems, and acknowledge full responsibility for failure to do so. I certify that the above named person will provide proper care to meet the health and safety needs of:

_____
Name of Consumer(s)

_____ _____
Date Parent/Guardian Signature

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