RESPITE CARE AGREEMENT

For use of this form, see AR 608-75; the proponent agency is OACSIM

As a condition of receiving respite care services for the individual with a disability in my/our care, I/we agree to the following:

I/we shall not hold the _____ responsible or liable in any way whatsoever as a result of any incident which might be construed to affect adversely the health, safety, or welfare of the person with a disability or other member of the same household in the caregiver's charge, while he or she is cared for by a respite caregiver.

I/we shall provide the Respite Care Coordinator and caregivers of the Respite Care Program with all the necessary facts to enable the individual with a disability to be cared for in a healthful, safe, and responsive manner including:

Clear, written instructions on medical care and the giving of medication.

Where I/we can be reached while the individual with a disability is in the caregiver's charge, and the names and telephone numbers of an emergency contact and physician.

Clear, written descriptions of the special needs, capabilities, likes and dislikes, important habits, etc., of the individual with a disability.

I/we shall make the final decisions whether or not to utilize the services of a particular caregiver for the respite period.

I/we shall inform the Respite Care Coordinator of other household members who will also need care or supervision in my/our absence, and of any special household circumstances about which a caregiver would need to be aware.

I/we shall pay the contribution agreed upon directly to the caregiver in cash, upon completion of the respite period.

The Respite Care Coordinator shall have my/our permission to arrange for an alternate caregiver for our family member with a disability, if he/she is unable to contact us *(or the person designated by us as responsible in our absence)* to inform us that the caregiver initially providing care is unable to complete the respite period.

I/we shall provide on request to the Respite Care Coordinator my/our assessment of the performance of a caregiver who has provided a respite care service to me/us in order to assist him/her in evaluating the overall performance of that caregiver and/or the program.

SIGNATURE OF PARENT, GUARDIAN, OR RESPONSIBLE FAMILY MEMBER	DATE *(YYYYMMDD)*
SIGNATURE OF RESPITE CARE COORDINATOR	DATE *(YYYYMMDD)*