

Family-Selected Respite Provider Waiver

Instructions: This form is to be completed by the Individual, the Individual's Parent, or the Individual's Guardian. After completing this waiver, return it via fax, email or mail as noted above. Then, give or forward the Provider Packet (letter, application, and W-9) to the family-selected respite provider for them to complete and return. Once both have been returned, please contact us to issue respite vouchers.

Your Name:

Name of Individual:

Respite Provider's Name:

Provider's Phone:

County: Hamilton

The above-named individual is: Myself My Child My Ward

I select the following as a respite care provider for the above-named individual:

By my signature below, I certify that the health & safety needs of will be met and no liability shall be incurred by the Southwestern Ohio Council of Governments, Butler, Clermont, Greene, Hamilton, Montgomery, or Warren County Boards of Developmental Disabilities for any act or omission committed by the provider of service that I have chosen or by person(s) acting on behalf of the provider of service that I have chosen.

Furthermore, I release, indemnify, and hold harmless the Southwestern Ohio Council of Governments, Butler, Clermont, Greene, Hamilton, Montgomery or Warren County Board of Developmental Disabilities and their respective offices, employees, and agents from any suit or other legal proceedings arising from any act or omission committed by the provider of service that I have chosen or by person(s) acting on behalf of the provider of service that I have chosen.

I will provide, or cause to be provided, any training that may be needed for any person or persons I have chosen to work with

I will assure that the provider of service and any person(s) acting on behalf of the provider will be given a copy of, and will read and understand, the Rights of Person with Developmental Disabilities in Ohio Revised Code Section 5123.62.

I will assure that the provider of service and any persons(s) acting on behalf of the provider will acknowledge the obligation by law to report major unusual incidents, as defined in Rule 5123.2-17-02 of the Ohio Administrative Code, to the Office of Incident Review of the County Board of DD, and/or to the appropriate local law enforcement agency, as outlined in Ohio Revised Code Section 5123.61. I acknowledge that I have been given a copy of, and have read, Ohio Revised Code Section 5123.61 and Rule 5123:2-17-02 of the Ohio Administrative Code. I will assure that the provider of service and any persons(s) acting on behalf of the provider will be given, and will read, Ohio Revised Code Section 5123:61 and Rule 5123:2-17-02 of the Ohio Administrative Code.

In Hamilton County all incidents of suspected abuse or neglect, and other major unusual incidents must be reported to the Department of Safety and Protection via MUIP@hamiltondds.org or (513) 794-3308 in accordance with 5123:2-17-02 of the Ohio Administrative Code. (copy provided upon request)

Signature of Individual / Parent / Guardian

Date

Southwestern Ohio Council of Governments (SWOCOG)
412 S. East St.
Lebanon, OH 45036
Phone (513) 559-6953, Fax (855) 763-3050
Michelle.Hoying@swocog.org

FAMILY SUPPORT SERVICES PROVIDER APPLICATION
(this is for information only it does not need to be returned to me)

Your name has been suggested by _____ as a potential provider of respite care for _____. Because the Family Support Services Program (FSSP) at least in part, funds this respite care, you must be approved as a provider before vouchers to the family can be authorized.

Enclosed is a provider application (blue form). Please note that your social security number is required for tax purposes so you must also complete the W9 form. This information will be used if we must file an IRS Form 1099, Statement of Recipients of Miscellaneous Income, at the end of a calendar year as well as for audit purposes. This filing will be required if we pay you \$600 or more in the calendar year. Incomplete or illegible forms will delay the process of approval.

We use a voucher system to pay for services. Vouchers can only be issued to providers whose application has been received and approved. Families are required to call and request a voucher before you provide service. If this is not done, we cannot guarantee your payment. Please ask the family to show you the voucher before you provide the care. You must return a copy of the voucher within 30 days of the "valid through" date listed on the voucher to be guaranteed payment. Payment will be issued within 45 days of receipt of the signed voucher.

Your completed packet (Provider Application and W-9) can be returned via email, fax or mail as noted below. If you have any questions, don't hesitate to reach out.

Sincerely,

Michelle Hoying
Family Support Services Program Coordinator
412 S. East St.
Lebanon, OH 45036
Michelle.Hoying@swocog.org
p: 513-559-6953
f: 855-763-3050

Southwestern Ohio Council of Governments (SWOCOG)
412 S. East St. Lebanon, OH 45036
Phone (513) 559-6953 Fax (855) 763-3050
Michelle.Hoying@swocog.org

Instructions: Please fill out all areas, sign, and return. PLEASE PRINT!
If your application is illegible, it will delay processing and could result in inaccurate information being used to issue vouchers and payments

Respite Provider Application

Individual you are providing respite care for: _____

County family enrolled: Hamilton

Provider's Information

Social Security Number: PLEASE COMPLETE ATTACHED W9

Name: _____ **Birthdate:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Other Phone:** _____

Email Address (if applicable): _____

Terms of Agreement

I understand that if I am selected as a family-selected provider, I will be providing respite services for _____ . I agree to accept vouchers, to be redeemed with the Family Support Services Program (FSSP) equal to the FSSP co-payment portion of care. I understand that by State requirements, FSSP has up to 45 days to issue a check after the voucher is received in the FSSP office. The family share of the cost, if any, must be collected by me. FSSP ASSUMES NO LIABILITY FOR PAYING THE FAMILY SHARE OF COSTS, IF ANY.

I also understand that if I receive payment for services of \$600.00 or more within a calendar year (January 1- December 31) that a 1099 will be sent to the IRS and I will have to pay taxes on that amount.

The family selected provider acknowledges that he/she:

1. Is age eighteen or older.
2. Shall not provide services to any eligible individual whose needs the provider cannot meet, nor accept payment for services not provided.
3. Shall not provide respite services to his/her child or to his/her spouse enrolled in the FSSP.
4. Assures that no liability shall be incurred by HCBDD or SWOCOG for services provided by this provider or the actions of the provider.
5. Does not reside in the same household as the individual receiving services.
6. Is not employed by the Hamilton County Board of Developmental Disabilities.
7. Must report all incidents of suspected abuse or neglect, and other major unusual incidents to the Department of Safety and Protection via MUIP@hamiltondds.org, or phone (513) 794-3308 in accordance with 5123:2-17-02 of the Ohio Administrative Code. (Copy provided upon request)

Signature

Date

The mission of the Southwestern Ohio Council of Governments is to provide support and solutions to county boards of developmental disabilities through cost-effective shared services that deliver value, satisfaction, and maximization of resources.

Request for Taxpayer Identification Number and Certification

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
2 Business name/disregarded entity name, if different from above	
<p>3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor or <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate single-member LLC</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► <u> </u> <small>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</small></p> <p><input checked="" type="checkbox"/> Other (see instructions) ► <u>Respite Provider</u></p>	
<p>4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) <u> </u></p> <p>Exemption from FATCA reporting code (if any) <u> </u></p> <p style="text-align: right;"><small>(Applies to accounts maintained outside the U.S.)</small></p>	
5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
6 City, state, and ZIP code	Southwestern Ohio Council of Govts. 412 S. East St. Lebanon, OH 45036
7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number					
<u> </u>	-	<u> </u>	-	<u> </u>	<u> </u>

or

Employer identification number									
<u> </u>	-	<u> </u>							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ►
	Date ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.*