



Warren County Board of Developmental Disabilities

Megan K. Manuel, Superintendent

42 Kings Way • Lebanon, OH 45036

Phone: 513.228.6400 • Fax: 513.932.1927 • www.warrencountydd.org

Supporting people with disabilities and their families to achieve what is important to them.

Dear Family Chosen Providers and Family Support Family:

Attached are various forms that need to be completed prior to respite services occurring. The last two pages are for the family to fill out and sign. The rest is for the Provider and all forms need to come back to Family Support at one time. Federal law requires that any person, who is working with children, must have a criminal background check.

Typically, it takes approximately 2 weeks to receive the results of the background screening. We understand that the family has chosen provider because they know them and have pre-screened them as a caregiver so we do allow services to occur during this process. In the event that the respite provider has record of felonious charges, continuation of respite services will be evaluated with the family. The FS Program has the right to stop services with a provider who has a criminal background.

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. Also attached is a consent/waiver form) for the family you will be providing respite care for to complete. HR Profile to do criminal background check. 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 request a voucher before they 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 45 days of the "valid through" date listed on the voucher to be guaranteed payment. Payment will be issued within 1 to 4 weeks of receipt of the signed voucher.

All documents either need to be emailed back to me in PDF format or can be mailed to the following address:

Warren County Board of Developmental Disabilities

Attn: Katrina Steele

410 S. East Street

Lebanon, Ohio 45036

Please call or email Katrina.Steele@warrencountydd.org if you have any questions regarding the Family Support Program.

Sincerely,

Katrina Steele

Katrina Steele
Family Support Coordinator



EMPLOYMENT PROFILE

Authorization Form to be Fully Completed and Signed

***** If Hand-Written, Please Print Clearly *****

Human Resource ProFile, Inc.
8506 Beechmont Ave.
Cincinnati, OH 45255
Ph: 800-969-4300
Fx: 513-388-4320; orders@hrprofile.com

Name _____			
Last Name	First Name	Middle Name	Maiden Name
Address _____		City/State _____ / _____	County _____ Zip _____
Previous _____		City/State _____ / _____	County _____ Zip _____
Social Security # _____		Driver's License Number _____	
Date of Birth _____ / _____ / _____ Month Day Year		DOB used for identification purposes ONLY. Driver's License State of Issuance _____	
E-mail address _____		Best phone number to reach you: _____	

SCHOOLS ATTENDED

Educational achievement is only considered as dictated by the respective job requirements.

School Name	City / State	Dates		Graduate? Y / N	Degree Type Earned
	Campus / Phone Number	From	To		
High School:					
If GED received, list state and district or military facility, and year received:		Name as it appears on high school diploma or GED certificate:			
College School Name:	City/State/Campus/Phone Number	From	To	Graduate?	Degree Type Earned
Major area of study:		Name used at time of graduation or final attendance:			
Grad./Tech./Other School Name:	City/State/Campus/Phone Number	From	To	Graduate?	Degree Type Earned
Major area of study:		Name used at time of graduation or final attendance:			

CRIMINAL HISTORY

The presence of Criminal Records does not automatically disqualify an applicant.

Complete the following section ONLY if you have received an offer (or conditional offer) of employment.

Have you ever pled guilty, been convicted, entered a plea of no contest, had prosecution deferred, had prosecution diverted (diversion program), or adjudication withheld for any crime? Yes No

If Yes, CALIFORNIA, CONNECTICUT, & N.Y. applicants: provide conviction records ONLY. NY applicants: exclude all sealed records. CALIF. applicants: exclude all sealed records, marijuana cases over 2 years old; list juvenile records of felony or misdemeanor convictions for sexual offenses or drug possession within last 5 years.

All Other applicants, if Yes, list All Offenses, including Traffic and/or Criminal, and the City, County, and State of the Offense(s).

Year	Offense	City	County	State

Please check here if additional pages are attached listing more offenses: Yes, see additional sheets

I hereby authorize the procurement of the report and authorize and direct the release to Human Resource Profile, Inc., an independent contract agency, information held by any parties regarding my previous employment, my criminal history record and/or record of convictions in federal, state, and local files for violations of any federal, state, local statutes or ordinances, my credit history, workers' compensation history, driving record, government agency lists, and scholastic records and hereby release said persons, schools, companies, courts, agencies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I further understand this information may be reviewed periodically by Human Resource Profile, Inc. and reported to my prospective (or if hired, my current) employer. I hereby acknowledge that Human Resource Profile, Inc. cannot vouch for or guarantee the accuracy of information provided by third parties. Accordingly, I release Human Resource Profile, Inc., its agents and/or my prospective/current employer from any and all liabilities arising out of any errors or omissions regarding my background information, and authorize Human Resource Profile to release any and all information to my prospective employer. A facsimile or electronic copy with electronic signature shall be considered as valid as the original. If so required in your jurisdiction, do not consent to a criminal background check until after receiving an offer (or conditional offer) of employment.

Signature _____ Date _____

TO BE COMPLETED BY:

Date Sent: _____	From: _____	Acct # _____
Time Sent: _____	Phone: _____	
Conviction History	Education Verification	MVR
Federal District Criminal	Violent Sex Offender Search	Credit
National Crim. Database	Statewide Criminal Search	Special Request: _____

When requesting a report for employment purposes from HRP, you must also certify to HRP that you have provided the applicant/employee with the disclosure form and obtained the applicant/employee's consent to procure the report. HRP's two or three page authorization profile forms comply with these requirements.



IMPORTANT DISCLOSURE

FCRA Required
Clear and Conspicuous Notice

Please read before completing and signing the Employment ProFile Form.

I HAVE BEEN INFORMED IN WRITING AND ACKNOWLEDGE THAT A "CONSUMER REPORT" AND/OR AN "INVESTIGATIVE CONSUMER REPORT" MAY BE OBTAINED ON ME FOR EMPLOYMENT PURPOSES. I UNDERSTAND THAT SUCH REPORTS MAY INCLUDE INFORMATION REGARDING MY CREDIT HISTORY, CRIMINAL RECORD, EDUCATION HISTORY, WORK HISTORY, AS WELL AS MY CHARACTER, GENERAL REPUTATION, PERSONAL CHARACTERISTICS, OR MODE OF LIVING. AN "INVESTIGATIVE CONSUMER REPORT" INVOLVES PERSONAL INTERVIEWS OF SOURCES SUCH AS YOUR NEIGHBORS, FRIENDS, OR ASSOCIATES TO OBTAIN INFORMATION AS TO YOUR CHARACTER, GENERAL REPUTATION, PERSONAL CHARACTERISTICS, AND MODE OF LIVING.

I FURTHER UNDERSTAND THAT THIS "CONSUMER REPORT" AND/OR "INVESTIGATIVE CONSUMER REPORT" WILL BE COMPLETED BY HUMAN RESOURCE PROFILE AND PROVIDED TO MY PROSPECTIVE EMPLOYER FOR EMPLOYMENT PURPOSES.

I FURTHER UNDERSTAND THAT WITH RESPECT TO ANY "INVESTIGATIVE CONSUMER REPORT" THAT MAY BE REQUESTED BY MY PROSPECTIVE EMPLOYER, I HAVE THE RIGHT TO REQUEST FROM MY PROSPECTIVE EMPLOYER DISCLOSURE OF THE NATURE AND SCOPE OF THE "INVESTIGATIVE CONSUMER REPORT" AS WELL AS A WRITTEN SUMMARY OF THE RIGHTS OF CONSUMERS TO OBTAIN AND DISPUTE INFORMATION IN CONSUMER REPORTS.

I ALSO ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS STATEMENT.

Signature_____ Date_____

Human Resource ProFile, Inc.

8506 Beechmont Avenue * Cincinnati, OH 45255-4708 * 800/969-4300 * 513/388-4300 * Fax 513/388-4320

ARBITRATION AGREEMENT

(This Agreement cannot be altered, or else it is rendered null and void)

_____ is an applicant/employee (the "Applicant/Employee") for employment with _____ (the "Prospective Employer/Employer") and understands that the Prospective Employer/Employer will request that a Background Check be performed on him/her by Human Resource ProFile, Incorporated ("HRP") as a condition of employment.

For good and valuable consideration, including prospective or continued employment, the sufficiency of which is hereby acknowledged, the Applicant/Employee, Prospective Employer/Employer and HRP (hereinafter referred to individually as a "Party" and collectively as the "Parties") hereby agree that any and all claims or causes of action against a Party(ies) by another Party(ies) under the Fair Credit Reporting Act ("FCRA") or any other applicable federal or state law, whether based in tort, contract or other basis, which arises in any way from the Background Check Report, disclosures required under the FCRA or state law, any adverse action taken by the Prospective Employer/Employer or by HRP on behalf of the Prospective Employer/Employer, or any other alleged violations of federal, state or local law, shall be arbitrated by the Parties in accordance with the Federal Arbitration Act ("FAA"). Such arbitration shall take place in the county in which the Prospective Employer/Employer is located or where the prospective employment was to take place or employment took place.

The arbitration required above shall be brought "on an individual basis only" and not "on a class action basis." The Applicant/Employee, Prospective Employer/Employer and HRP further agree that the validity of this Arbitration Agreement shall be determined solely by the arbitrator(s).

HRP is executing this Agreement on behalf of itself and in its capacity as a duly authorized agent of the Prospective Employer/Employer as per the HRP Service Agreement therewith. This Agreement may be executed using electronic and/or facsimile signatures, and such signatures shall have the same force and effect as if they were original signatures, and shall be effective as of the date that it is fully executed. If any provision hereof is declared to be unenforceable, the remainder hereof shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have signed this Agreement as of the date set forth opposite their respective signatures.

Applicant/Employee's Signature

Date

(Print Name of Prospective Employer/Employer)

Human Resource ProFile, Incorporated

By:  _____

By:  _____

HRP as its duly authorized Agent

Print Name: Mark Owens

Print Name: Mark Owens

Title: President

Title: President

Date: _____

Date: _____

Human Resource ProFile, Inc.

8506 Beechmont Ave. * Cincinnati, OH 45255 * Ph: 800/969-4300 * Fx: 513/388-4320

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	
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. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ 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. <input checked="" type="checkbox"/> Other (see instructions) ► Respite Provider	
4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ (Applies to accounts maintained outside the U.S.)	
5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional) Southwestern Ohio Council of Govts. 412 S. East St. Lebanon, OH 45036
6 City, state, and ZIP code	
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									
				-				-	
or									
Employer identification number									
				-					

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- 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.

Warren County Board of Development Disabilities
410 S. East Street
Lebanon, OH 45036
Phone (513-228-6432
Katrina.Steele@warrencountydd.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

Individual you are providing respite care for: _____

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-chosen provider, I will be providing respite services for the _____ family. I agree to accept vouchers, to be redeemed with the Family Support Program. I understand that by State requirements, FS has up to 45 days to issue a check after the voucher is received in the FS office.

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 chosen provider acknowledges that he/she:

1. Provider is age 16 or older with a valid Driver's license.
2. Shall not provide services to any eligible individual whose needs the provider cannot meet, nor accept payment for services not provided.
3. Assures that no liability shall be incurred by WCBDD or SWOCOG for services provided by this provider or the actions of the provider.
4. Does not reside in the same household as the individual receiving services.
5. Is not employed by the Warren County Board of Developmental Disabilities.
6. Must report all incidents of suspected abuse or neglect, and other major unusual incidents to the Department of Safety and Protection via phone (800) 800-6847 in accordance with the Ohio Administrative Code.

Signature

Date

Family Waiver

This form is to be completed by the Individual, the Individual's Parent, or the Individual's Guardian if a family-selected respite care provider is being utilized.

Family Chosen Respite Care Provider for _____
(Name of Individual enrolled)

Name: _____ Phone Number: _____
(Name of Provider)

By my signature below, I certify that the health & safety needs will be met and no liability shall be incurred by the Southwestern Ohio Council of Governments or Warren County Board 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 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 the enrolled individual.

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 the Ohio Administrative Code, to the Office of Major Unusual Incident Department of the WCBDD, and/or to the appropriate local law enforcement agency.

In Warren County all incidents of suspected abuse or neglect, and other major unusual incidents must be reported to (800) 800-6847 in accordance with the Ohio Administrative Code.

Signature of Parent / Guardian

Date

Please sign, date and return this form to:

**WCBDD - Family Support Program
410 S. East Street, Lebanon Ohio 45036**

Katrina.Steele@warrencountydd.org

RESPITE OR CHILDCARE/AGENCY REQUEST

ONCE REQUEST IS APPROVED YOU WILL RECEIVE A RESPITE OR CHILDCARE/AGENCY VOUCHER(S) MY MAIL. A voucher must be requested 10 days PRIOR TO receiving respite services.

SERVICES REQUESTED BY: _____

INDIVIDUAL ENROLLED: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER _____

EMAIL: _____

CHILDCARE / AGENCY ONLY

Childcare / Agency Name: _____

Total number of vouchers _____ Weekly or Monthly cost
per voucher _____

Date range needed: _____

Payment to: _____

If we are paying you a completed W9 form must be on file

RESPITE ONLY (A completed provider application must be on file)

Respite Provider Name: _____

Total number of vouchers _____ Weekly or Monthly cost
per voucher _____

Date range needed: _____

NOTE: 10-24 HOURS EQUALS ONE DAY. WE PAY A MAXIMUM OF 10 HOURS A DAY.

Family Chosen Provider Rate - \$11.00 an hour
Certified Independent Provider Rate - \$22.00 an hour
Certified Agency Provider Rate - \$25.00 an hour