



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:

Attached are the following forms that will need to be completed prior to when Respite Services begin Pages (1-5) are required to be filled out by the Family Chosen Provider.

Page (6) is required to be filled out by the Family.

Please return all forms at one time in PDF format to Familysupport@warrencountydd.org

- **HR Employment Profile: (Pages 1-3) (This is required by the Federal Law for a background check to be completed on the provider the family chooses)**
 - This process takes up to two weeks to receive the results.
 - We understand that this can be an inconvenience, we do allow a Respite provider to start services before the background check is received as a courtesy to the family.
 - If the background check should come back ex: with a felony the Respite services will need to stop immediately.
- **W-9 Form: (Page 4)**
 - This is required to be filled out for tax purposes
 - This information will be used for the Respite Provider to be set up as a Vendor in our system
 - If the Family Chosen Provider receives more than \$600.00 in wages for the year they will be sent a 1099 from the IRS at the end of the year to claim as income on their taxes
 - Please fill out Line 1, 2, 5, 6, 7
 - Part 1 Social Security Number
 - Sign and Date
- **Family Chosen Provider Application: (Page 5)**
 - Please fill in all areas, if your application is illegible, it will delay processing and could result in inaccurate information being used to issue vouchers and payments.
- **Family Waiver: (Page 6) (To be filled out by the Family)**
 - Please read over content, fill out the form, sign and date. If this form isn't completed it will hold up the process.
- We use a Voucher system to pay for services. The Vouchers can only be issued to providers whose application has been received and approved. Families are required to request a voucher before they provide any services. If this is not done, we cannot guarantee your payment. Please ask the family to show you the voucher before you provide the care. Please return a copy of the Voucher within 45 days of the end date of the Voucher. If the Vouchers are not received within 45 days they will be closed out and not able to be re-opened. Once the Voucher is submitted it will be reviewed, please allow 2-4 weeks for your payment to arrive.

Please email Familysupport@warrencountydd.org with any questions.

Sincerely,

LeAnn Powers, Division Secretary



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

Warren County Board of Development Disabilities
410 S. East Street
Lebanon, OH 45036
Phone (513-218-0410)
Familysupport@warrencountydd.org

*Please fill out the entire form completely please print, sign and return.
If the 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 W-9

Name: _____ **Birthdate:** _____

Street Address: _____

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

Phone Number: _____

Email Address: _____

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, Family Support has up to 45 days to issue a check after the voucher is received in the Family Support Office. I understand that if I receive payment for services of \$600.00 or more withing a calendar year (January1-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. Doesn't reside in the same household
5. Is not employed by the Warren County Board of Developmental Disabilities
6. Needs to report all incidents of suspected abuse or neglect, and other major incidents to the Department of Safety and Protection via phone (800) 800-6847 in accordance with the Ohio Administrative Code.

Signature: _____ **Date:** _____

**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.**

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)	
	2 Business name/disregarded entity name, if different from above.	
	3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ (Applies to accounts maintained outside the United States.)
	3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions <input type="checkbox"/>	
	5 Address (number, street, and apt. or suite no.). See instructions.	Requester's name and address (optional)
	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. See also *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:

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
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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.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

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: _____ **Date:** _____

Please email form in PDF Format to Familysupport@warrencountydd.org