

**Family Member and Limited Provider Signature Sheet
Level I - Informal Respite Services**

Name of individual receiving informal respite services:	
Name of responsible family member:	
Name of limited provider:	

FAMILY MEMBER RESPONSIBILITY

I verify that I am a family member and am able and willing to take responsibility to:

- Monitor the delivery of informal respite services to my family member as outlined in the ISP
- Provide orientation and annual training to the limited provider regarding:
 - Activities required to meet the needs and preferences of my family member including any training needs included in the ISP
 - Information related to the health and welfare of my family member
 - Reporting requirements relating to incidents adversely affecting health and safety
 - The rights of individuals with developmental disabilities
- Communicate with the person responsible for service and support administration for my family member
- Monitor and report unusual and major unusual incidents that involve my family member
- Monitor health management and behavior support activities and take immediate actions as necessary to maintain the health, safety, and welfare of my family member

Signature of Family Member

Date

Relationship to Individual

LIMITED PROVIDER RESPONSIBILITY

I verify that, prior to delivering services, I received training to the extent necessary to meet the needs and preferences of the individual who has selected me to provide informal respite services.

- I have a copy of the Service and Payment Agreement, have reviewed the services listed on it and understand how to provide the supports/services and meet the training needs of the individual as outlined in the ISP.
- I understand that I can provide informal respite only to the individual named above or to multiple individuals who live in this same family setting and, if I am a parent, only if my son/daughter named above is at least 18 years old.
- I understand that if I am no longer able to meet the needs and preferences of the individual I shall notify the individual or family member.

Signature of Limited Provider

Date

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