Ohio | Department of Developmental Disabilities

PROVIDER CERTIFICATION APPLICATION ADDENDUM
INSTITUTIONAL RESPITE

Please carefully review and complete this form and submit all appropriate documentation.

NAME OF AGENCY PROVIDER	
NAME OF CEO OF AGENCY PROVIDER	

DEFINITION OF INSTITUTIONAL RESPITE

"Institutional respite" means Home and Community-Based Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care, in facilities certified as Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) or other facilities licensed by the department under section 5123.19 of the Ohio Revised Code.

The applicant must meet one of the following standards. Please check the box to indicate that the documentation is included.

1. ICFs/MR licensed by the Ohio Department of Developmental Disabilities
   - ☐ Submit documentation of certification as an ICF/MR by the Ohio Department of Health and
   - ☐ Submit documentation of licensure by the Ohio Department of Developmental Disabilities under Section 5123.19 of the Ohio Revised Code

   OR

2. ICFs/MR licensed by the Ohio Department of Health
   - ☐ Submit documentation of certification as an ICF/MR by the Ohio Department of Health and
   - ☐ Submit documentation of licensure by the Ohio Department of Health under Chapter 3721. of the Ohio Revised Code

   OR

3. Other facilities licensed by the Ohio Department of Developmental Disabilities
   - ☐ Submit documentation of licensure by the Ohio Department of Developmental Disabilities under Section 5123.19 of the Ohio Revised Code

Each applicant must initial the following to indicate your understanding and assurance to comply.

_____ The provider shall maintain certification/licensure (as indicated above), as applicable.

_____ The provider shall participate in development of the individual's service plan meetings if and when requested by the individual's interdisciplinary team.

I have submitted the evidence as requested, understand the requirements, and certify that I will meet the above initialed assurances. I understand that misrepresentation or falsification of this application or any supporting documentation may result in denial or revocation of provider certification.

_____ _____

Signature of Agency CEO Applicant Date

Return completed application with supporting documentation to:

Ohio Department of Developmental Disabilities
Office of Provider Certification
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-877-289-3636
Or email Provider.Certification@dmr.state.oh.us