

Respite Care Agreement

DATE: _____

CHILD NAME	CHILD DOB	CHILD AGE

RESPITE REQUESTOR:	
AGENCY: <input type="checkbox"/> FFN <input type="checkbox"/> CHS <input type="checkbox"/> FBCH <input type="checkbox"/> UMCH <input type="checkbox"/> HC4T	
NAME:	
ADDRESS:	
PLANNED DURATION:	DAYS AVAILABLE:
TO = Days	

RESPITE PROVIDER:	Respite Rate:
AGENCY: <input type="checkbox"/> FFN <input type="checkbox"/> CHS <input type="checkbox"/> FBCH <input type="checkbox"/> UMCH <input type="checkbox"/> HC4T	\$15/day
NAME:	
ADDRESS:	

Send Form to: Your Agency representative and send a COPY OF THIS AGREEMENT TO THE COUNSELOR.

As a licensed/approved respite care provider for the Department of Children and Family Services, I/we agree to the following conditions considered essential for the welfare of this child placed in my/our care under the respite care program:

1. This child/youth is placed in my/our care on a short-term basis and is at all times under the supervision and control of the Department/LCI.
2. I/We am/are fully and directly responsible to the Department/LCI for the care of the child/youth.
3. I/We will take no action to acquire legal custody or guardianship of the child.
4. I/We will hold confidential all information about the child and his family and will discuss such information only with a representative of the Department/LCI or with appropriate specialists at the request of the Department/LCI.
5. I/We will not permit the removal of the child from my/our care, except by an authorized representative of the Department/LCI or by instruction of such representative.
6. I/We will not give the child into the care or physical custody of any other person(s), including natural parent(s), without the consent of a representative of the Department/LCI.
7. I/We will cooperate, if arrangements are made by the Department/LCI, for visits with the child by his parent(s) or other relative(s).
8. I/We will cooperate with the Department/LCI in plans for the child, such as appointments for the child's medical and psychological needs, court hearings, etc.
9. While I/we am/are providing respite care for the child named above, I/we will accept other children into our home for care only from the Department/LCI.
10. I/We will accept the above board rate per day on behalf of the child in accordance with the Department's rate structure for respite care.
11. I/We will incur no expenses for which I/we expect reimbursement without authorization from the Department/LCI.
12. The Department/LCI may remove the child from my/our care at any time, but will, whenever possible, give us at least 24 hours notice.
13. I/We will notify the Department/LCI immediately of any change in our address, employment, living arrangements, or family composition.
14. I/We will comply with all requirements for respite care providers as prescribed by the Department/LCI.

Respite Provider's Signature	- - Social Security Number () -	/ / Date / /
Agency Representative	Phone Number	Date