Boundless

1021 Checkrein Avenue Columbus, Ohio 43229-1106 614/844-5847 Fax 614/844-5916

Application for Approval of Family-Chosen Provider

Please Read and Be Aware: The family certifies by signature that the family assumes responsibility for the health and safety needs of the individual and that the county board and Boundless shall incur no liability for respite services provided by the identified familyselected respite provider. The family may identify or utilize any person/agency to their liking for familyselected private provider services. By signature, the family acknowledges that reimbursement will be made directly to the family for this provider, in the family name for the familyselected private provider identified. For an agency provider, payment will be made directly to the agency.

NOTE: IF THE FAMILY-SELECTED RESPITE PROVIDER IS A PRIVATE INDIVIDUAL, THEN THE INCLUDED W-9 FORM IS FOR FAMILY USE ONLY (TO BE KEPT BY THE FAMILY).
NOTE: IF THE FAMILY-SELECTED RESPITE PROVIDER IS AN AGENCY OR PRIVATE COMPANY, THE COMPLETED W-9 FORM IS TO BE SENT TO THE FAMILY SUPPORT DEPARTMENT WITH THIS FORM.

Select by checkmark either a Private Provider or CTE Provider below.
Only one (1) provider and one (1) type of provider per each form.

☐ **Private Respite Provider (PP)** ***OR*** ☐ **Counseling, Training and Education (CTE)**

<u>Only one must be selected by checkmark, either PP or CTE</u>. All information is required on both sides of this form. W-9 forms are required for new CTE providers or new company providers.

Provider Information

(All Applicable Information must be completed)

PLEASE TYPE OR PRINT CLEARLY

Family Name Requesting Provider: _____

Family-Selected Provider Name: _____

If minor, Parent/Guardian signature: _____

Provider's Soc. Sec. #: _____

Company Name: _____

Federal I.D # (required with W-9 form for new providers): _____

Provider's Address_____

City, State, Zip _____

Phone number _____ Work number _____

Type of Service Provided: _____

(Over) All Applicable Information Must Be Completed

_____

Past Experience in Delivering Service: _____

_____

Certification or Training of Personnel: _____

_____

Provider Hourly or Qtr Hour charge _____

_____ DATE: _____

SIGNATURE OF PROVIDER (Required)

_____ DATE: _____

SIGNATURE OF FAMILY REQUESTING PROVIDER (Required)

Family certifies that no liability shall be incurred by Boundless or the Franklin County Board of DD for services provided by this provider.

FOR OFFICE USE ONLY: DATE RECIEVED_____ APPROVED_____ NOT APPROVED____ INPUT DATE_____ BY_____

Please Look Over this Form to Ensure:

1. ALL APPLICABLE INFORMATION IS COMPLETED
2. INCLUDED SIGNATURES REQUIRED
3. ONLY ONE (1) PRIVATE RESPITE PROVIDER (PP) IDENTIFIED ON THIS FORM BY CHECKMARK

   OR

   ONLY ONE (1) COUNSELING, TRAINING AND EDCUATION PROVIDER (CTE) IDENTIFIED ON THIS FORM BY CHECKMARK
4. FEDERAL I.D. NUMBERS AND W-9 FORMS ARE SUBMITTED WITH THIS FORM FOR ALL NEW FAMILY-CHOSEN AGENCY PROVIDERS IN THE PRIVATE PROVIDER (PP) AND COUNSELING, TRAINING AND EDUCATION (CTE) CATEGORIES.

SEND THIS TWO-SIDED PAGE TO FAMILY SUPPORT & RESPITE SERVICES, 1021 CHECKREIN AVE, COLUMBUS, OHIO 43229 FOR FAMILY-CHOSEN APPROVAL OF PROVIDERS. ALL APPLICABLE INFORMATION MUST BE COMPLETE.