Family Directed Resources
Respite Verification Form

I assure that my family selected provider meets the needs of my family. I absolve the Erie County Board of Developmental Disabilities and Ability Works, Inc. of any and all liability for this provider.

Respite Provider Name:_____ Provider Phone Number:_____

Provider Address: _____

Dates of Service: _____

Cost of Service: _____ Please check one: ☐Hourly ☐Weekly ☐Daily

Hours provided in the day: _____

Or attached letter from provider

Child's Name:_____ Child's Date of Birth:_____

☐Participant of Project Lifesaver ☐Documentation of 1:1 or aide services
☐Intense medical needs under age 11
(Children under 11 are not eligible for respite services unless of extenuating medical issues.)

*****If respite provider has been paid, attach the respite receipt signed by the provider.*****

*****All respite payments must be submitted within 30 days from date of respite*****

Requests will be honored if program funds are available and request is consistent with the definition of policy approved services. Payments will be drawn from the calendar year in which the services are rendered. To ensure prompt payment, the family must honor requested deadlines for submitting completed requests.

Fraudulent use of funds may result in termination of FDR for 1 year.

Respite Provider Signature:_____ Date: _____

Family Signature:_____ Date: _____