Respite Provider Employment Disclaimer and Release

1. Read and Initial beside each numbered statement on the form.
2. Sign acknowledging that you agree to the conditions listed
3. Print Name
4. Date Form

5. Send the form to SC Respite Coalition by doing one of the following:

   - Email to training@screspitecoalition.org
   - Fax to: 803.529.5229 – If you fax the form, please call the same day to ensure it was received.
   - Mail to:
     Attention: Stephanie Sumner
     SC Respite Coalition
     PO Box 493
     Columbia, SC 29202

South Carolina Respite Coalition

Breaks for family caregivers across the lifespan.

RESPITE CARE PROVIDER DISCLAIMER AND RELEASE FORM

As an applicant for potential employment by a household employer (family/consumer/responsible party) to provide respite care services under the SC Department of Disabilities and Special Needs' Family Selected Respite Care Program, I have read, fully understand, and agree to the following conditions:

1. _____(initial) Any employment relationship that arises between me as caregiver and the household employer is solely the responsibility of the household employer and myself, not the South Carolina Respite Coalition (SCRC), the Fiscal Agents (FA), or SC Department of Disabilities and Special Needs (DDSN).

2. _____(initial) I cannot begin to receive pay as a respite caregiver through the Family Selected Respite Care Program (Program) until both the household employer and I have successfully completed and submitted all required forms and other documentation to both the SCRC and the FA and have been notified of approval for the Program.

3. _____(initial) Any hours I may choose to work as a respite caregiver prior to or during the application and approval process will not be paid through the Program.

4. _____(initial) Any private arrangements I may choose to make with the household employer prior to, during, and/or outside of the parameters, provisions, requirements, or restrictions of the Program are solely the responsibility of the household employer and myself, not the SCRC, FA, or DDSN.

5. _____(initial) I am responsible to work with the household employer to receive training and orientation specific to expectations of the household employer, their home and family, and person(s) with disabilities with whom I will work, including their needs, desires, priorities, and concerns.

6. _____(initial) I have the right to refuse to work for a potential household employer/family/responsible party and/or person(s) with disabilities, or to leave their employ, at any time and for any reason.

My initials above and signature below acknowledges that I have read this entire disclaimer and release and that I fully understand and agree to the terms and disclosures contained in this document.

Signature: _____

Printed Name: _____

Date: _____