

# ALTERNATE CARE RESOURCES RESPITE PROVIDER AGREEMENT FORM

The following provisions outline the responsibilities undertaken by an independent provider for respite care services. The provider agrees, when possible, to assist in arranging fill-ins to cover respite he/she is unable to provide due to an emergency situation. When the provider is unable to arrange a fill-in, the primary care giver is ultimately responsible and may be required to forego respite or return to assume the responsibility of the client. Provider acknowledges that he/she will be responsible for incidental respite-related expenses, including mileage and basic needs of the child(ren), which are not provided by the primary caregiver. Provider acknowledges responsibility to carry out respite functions as requested by the primary caregiver. Respite functions include administering of medications as designated by the primary caregiver. Care is provided in accordance with quality care expectations of LaCrosse County Department of Human Services and any applicable statutes of the State of Wisconsin.

## PROVIDER EXPECTATIONS/QUALITY OF CARE

**I. QUALITY OF CARE**

- A. I, as a Respite Care Provider, have a commitment and agree to provide the highest quality care for those who are entrusted to me.
- B. I dedicate myself to the best interest of clients.
- C. I will seek the advice and counsel of the client's primary caregiver (foster parent).

**II. CONFIDENTIALITY AND PRIVACY**

- A. I will respect the privacy of clients and hold in confidence all information obtained in the course of professional service.
- B. Information received in confidence may be revealed in an emergency situation to appropriate professionals.

**III. MORAL AND LEGAL STANDARDS**

- A. I must show sensible regard for all social codes and moral expectations of the primary caregiver (parents, guardians, foster parents) and the community at large.
- B. I will adhere to the guidelines of caring for children who are in alternate care.

All Provider Agreement forms are due no later than the third day of each month. **Payment will be received approximately the weekend following the 3rd Thursday of the month.**

Bring or send Respite Provider Agreement form(s) to: **Attn: Sharon McHugh  
LaCrosse County Human Services, 300 4th Street North, LaCrosse WI 54601**

\_\_\_\_\_  
Child's Name (Print)

\_\_\_\_\_  
Foster Parent/Parent (Print)

Respite Started: \_\_\_\_\_  
Day Date Time

Respite Ended: \_\_\_\_\_  
Day Date Time

Respite Started: \_\_\_\_\_  
Day Date Time

Respite Ended: \_\_\_\_\_  
Day Date Time

Medication schedule/other comments: \_\_\_\_\_  
\_\_\_\_\_

During Respite Care, the primary caregiver (foster parent/parent) can be reached at phone number: \_\_\_\_\_

\_\_\_\_\_  
Respite Provider (Print)

\_\_\_\_\_  
Respite Provider Address (Print)

\_\_\_\_\_  
Provider Signature Date

\_\_\_\_\_  
Foster Parent/Parent Signature Date

### AGENCY USE ONLY

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RATE PER DAY \_\_\_\_\_ NO. of DAYS \_\_\_\_\_ SUPERVISOR SIGNATURE \_\_\_\_\_

TOTAL: \_\_\_\_\_

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