



Respite Provider Information (RPI)

Name of family caregiver: _____

Please complete the appropriate section for Individual Provider or Facility Provider

Individual Provider

Name of Respite Provider: _____

Address of Provider: _____

Phone of Provider: _____

Alternate phone: _____

Relationship to family: _____

Rate of pay per respite hour: _____

CPR Certified Yes _____ No _____

First Aid Certified Yes _____ No _____

I certify that all of the information on this application is true and accurate to the best of my knowledge. I realize that any information given falsely may cause me to be removed from the Family Directed Respite program permanently.

By signing below, I authorize the TN Respite Coalition to run a background check on me and share any and all information in the background check with the family caregiver mentioned above.

Signature of Respite Provider

Date of Birth: _____

Sex: _____ Race: _____

Date of Signature: _____

[The TN Respite Coalition is not allowed to pay for time worked by a provider whose record shows a felony or sex offender conviction. **After** the background check comes back clear, we can begin reimbursing for a respite provider's work.]

Facility Provider

Name of Camp/Agency: _____

Address: _____

Phone of Provider: _____

Alternate Phone: _____

Rate of Pay/Cost of Program: _____

Employees CPR Certified Yes _____ No _____

Employees First Aid Certified Yes _____ No _____

I certify that all of the information on this application is true and accurate to the best of my knowledge. I realize that any information given falsely may cause me to be removed from the Family Directed Respite program permanently.

Signature of Facility Representative

Date of Signature: _____

*******For Facility Providers: Please attach a copy of license, policy, or other documentation as proof that you complete background checks on your employees*******

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