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******

[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 we receive all required documentation, we can begin reimbursing for a respite provider’s work.]

Please contact the Tennessee Respite Coalition at 615-269-8687 with any questions about this form.