

*School of Hope*  
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Cheryl Cotter, Superintendent (Ext. 110) - [ccotter@scbdd.org](mailto:ccotter@scbdd.org)

**FAMILY SUPPORT SERVICES RESPITE CARE PROGRAM  
ASSURANCE FORM**

\_\_\_\_\_ hereby assures the Sandusky County Board of  
(Parent/Guardian Name)  
Developmental Disabilities that \_\_\_\_\_ shall provide for  
(Respite Provider Name)  
The health and safety of my family member, \_\_\_\_\_ while he/she is in respite care.  
(Client/Individual Name)  
The Sandusky County Board of DD is not responsible for the health and safety of \_\_\_\_\_  
(Client/Individual Name)  
while in the care of the non-certified provider.

**Effective for Services Rendered: 7/1/09 through 6/30/10 (Fiscal Year 2010)**

_____ Signature of Parent/Guardian	_____ Date
_____ Signature of Superintendent of Sandusky County Board DD	_____ Date
_____ Signature of Family Resource Coordinator	_____ Date

BOARD MEMBERS: Burk Tischler, President – Lisa Edris, Vice-President – Nancy Haynes, Secretary  
Janet Michaels– Rob Lytle – Red Haslinger – Kent Weickert

The Sandusky County Board of /Developmental Disabilities does not discriminate in provision of services or employment because of handicap, race, color, creed, national origin, sex or age.