Community Mental Health of Ottawa County
Respite Program
Respite Share Information

Respite Provider/Employee Name:_____

Please check all that apply:

- ☐ No, I do not wish to share my name as a registered respite provider/employee with other families enrolled in the Respite Program at Community Mental Health of Ottawa County (CMHOC).

- ☐ Yes, I do wish to share my name as a registered respite provider/employee with other families enrolled in the Respite Program at Community Mental Health.

- ☐ I would also like to have my name and phone number made available at the Community Mental Health Access Center and Customer Services Department, for referring me to families in need of a respite provider, but who are not receiving any services through CMHOC.

If yes, please provide the following information:

Name: _____

Phone #:_____

City: _____

Education/Experience: (Circle all that apply)	Associates Degree Bachelor's Degree Master's Degree Licensed Childcare Provider Licensed Foster Care Provider
Location of Care: (Circle all that apply)	In Providers Home Parent/Guardian's Home Community Setting
Willing to Provide Transportation?	_____
Population Served: (Circle all that apply)	MI (Person with Mental Impairment) DD (Person with Developmental Disability)

By signing this form I give Community Mental Health of Ottawa County permission to share the information I have provided with any families in the Respite Program for referral purposes.

_____ _____

Signature Date