



This letter serves as an assurance regarding the status of prescription medication management for the person supported (client) _____ by [Insert Parent/Provider Name] _____ at [Insert Client Address] _____.

As of the date of this letter, we confirm that the person supported, [Insert Client Name] _____, is currently on no prescription medications.

Per the regulations of the Colorado Department of Public Health and Environment (CDPHE) and the guidelines set forth by Pikes Peak Respite Services (PPRS), should the need arise in the future for prescription medications to enter the home, [Insert Parent/Provider Name] _____ will immediately notify PPRS of the change.

Upon notification, the Parent/Provider will be required to enroll in and complete the Qualified Medication Administration Personnel (QMAP) certification course through a CDPHE-approved provider before administering any medications to the client.

Failure to notify PPRS of a change in the medication status or to complete the QMAP certification may result in a suspension of services and could potentially lead to non-compliance with CDPHE regulations under the Colorado QMAP program.

Parent/Provider Responsibility:

I, [Insert Parent/Provider Name] _____, hereby acknowledge that

[Insert Client Name] _____ is currently not prescribed any medications.

I agree to inform Pikes Peak Respite Services immediately if prescription medications are prescribed to

[Insert Client Name] _____ in the future.

I understand that upon such notification, I will be required to complete the QMAP certification course and provide documentation of completion to PPRS in accordance with CDPHE requirements.

I acknowledge that administering any medication without proper QMAP certification is prohibited under Colorado law and CDPHE regulations.

Please sign and return this form to Pikes Peak Respite Services to acknowledge receipt and understanding of this assurance.

Signature of Parent/Provider:

[Insert Parent/Provider Name]

Date: _____