

Adams County Board of Developmental Disabilities
SERVICE REQUEST FOR FAMILY SUPPORT SERVICES

Mail original form to: Adams CBDD, 3964 Wheat Ridge Road, West Union, OH 45693

APPLICANT INFORMATION

Dependent Name:	Today's date:
Name of person making request:	Phone:

TYPE OF SERVICES SEEKING

Please check services you are interested in receiving if eligible:

<input type="checkbox"/> In-Home Respite	<input type="checkbox"/> Adaptive Equipment	<input type="checkbox"/> Training/Counseling
<input type="checkbox"/> Out of Home Respite	<input type="checkbox"/> Home Modification	<input type="checkbox"/> Other
<input type="checkbox"/> Emergency Respite	<input type="checkbox"/> Special Dietary	

Have you tried other sources to fulfill this need?
 Please list other sources you have tried:

RESPITE REQUESTS

Date(s) you are requesting respite:

Date:	Date:	Date:	Date:
Hours:	Hours:	Hours:	Hours:

Reason you are requesting respite?

Do you need a provider Y or N?
 If no, who is your chosen provider?

Address:	Phone:
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Note: All providers must be certified by ACBDD or have a Liability Form on file with the FSS program.

OTHER REQUESTS

Please use this space to describe your request:

SIGNATURE

I certify that the service(s) I am seeking is not covered by any other source including but not limited to Medicaid, waiver services, children services, etc. I further certify that if I have a co-pay I will make prompt payment to the appropriate person/agency. I understand if I misuse Family Support Service funds I may be penalized from future FSS funding.

Signature of agreement by responsible family member or guardian	Date:
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ADMINISTRATIVE USE ONLY

Approved:	Denied:	Co-pay:
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Comments:

Signature:	Date:
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