Ashtabula County Board of Developmental Disabilities

Enriching, empowering, and connecting people with their community

Transition Services -Referral for Eligibility Determination

Individual's Name: _____

Address_____

City, State, Zip_____

E-Mail Address_____

Birth Date:_____**Social Security Number:** _____

Family Contact Name: _____

Phone Number: _____

Name of School: _____

School District Point of Contact: _____

In an effort to plan for future support services, I am requesting a representative from the Ashtabula County Board of DD contact me to discuss long-term planning options for my child and to explore eligibility for Ashtabula County Board of DD services if this has not previously been established. I understand that I will need to provide the following in order to open a case:

- Verification of the qualifying diagnosis will need to be obtained
- Guardianship/Custody documentation (if applicable)
- Verification of Date of Birth (Birth Certificate)
- Verification of Social Security Number (Social Security Card)
- Proof of Insurance (Insurance card/Medicaid Card)
- Release of Information signed by the individual and/or parent/guardian
- Current Individual Education Plan (IEP)
- Current Evaluation Team Report (ETR)

Signature of Individual _____
(Required if over 18 without a court appointed guardian):

Parent/Guardian:_____

Date:_____**Time:**_____

Completed forms and documents as listed above returned to:
Ashtabula County Board of DD
Service and Support Administration
Attn: Intake/ Eligibility
2505 South Ridge Road East
Ashtabula, Ohio 44004

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, the below identified person, do hereby authorize the release of the following protected health information (PHI) to the following organization:

DEMOGRAPHICS

Individual's Name	DOB

Address

SSA OFFICE INFO

Organization: Ashtabula County Board of Developmental Disabilities
Department: Service and Support Administration
Address: 2505 South Ridge Road East
City: Ashtabula State: Ohio Zip: 44004

PERSON OR HEALTHCARE PROVIDER INFO

Person or Healthcare Provider authorized to release/receive information

Person/Healthcare Provider:

Department:	Phone:

Address:

City:	State:	Zip:

RECORDS TO RELEASE

Records authorized to be released:	This information will be used for the purpose of

Extent or nature of records to be released and dates:

This authorization will expire on:

I understand that I can revoke this authorization at any time by writing to the healthcare provider or to the Ashtabula County Board of Developmental Disabilities, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Ashtabula County Board of Developmental Disabilities may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

SIGNATURE

Individual or Representative Signature

Relationship to Individual