Ashtabula County Board of Developmental Disabilities

Enriching, empowering, and connecting people with their community

Family Support Services Program
Application for Services

Name of Individual:_____

Date of Birth:_____ Social Security Number:_____

Address:_____ Phone Number_____

City:_____ State:_____ Zip:_____

E-mail Address:_____

Name of Parent/Legal Guardian:_____

1. Has the applicant been determined eligible for services through ACBDD?_____

2. Does the applicant receive any of the following services:

   ☐ Ohio Home Care Waiver ☐ IO Waiver ☐ Level 1 Waiver ☐ Self Waiver

   ☐ Medicaid ☐ Medicare

3. Type of Services Requested: In-home Respite ☐ Out-of-Home Respite ☐
   Services (Children Under 3) ☐ Incontinence Supplies ☐ Specialized Nutrition ☐
   Specialized Equipment ☐ Recreation ☐ Camp ☐ Home Modifications ☐

   Other_____

I hereby certify that the information contained in this application is accurate and true. I also understand that this information is confidential and will be used for Family Support Services purposes only. I herby certify that I will follow all program rules and will only use funds for approved services.

_____ _____ Signature
Parent/Guardian Date

For Fiscal Use Only:

Eligibility for ACBDD services verified by:		Date:
Disapproved ☐	Reason:	
Approved ☐	Date:	Maximum Amount Allowed $
Fiscal Department Signature:		Date: