

DARKE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
4932 Children's Home Road, Greenville, Ohio 45331

FAMILY SUPPORT SERVICES ELIGIBILITY DETERMINATION

Date: _____ Initial Appl. _____ Annual Re-det. _____ **CONTRACT #** _____

Parent/Guardian (requesting service): _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

E-mail address: _____

Name of family member with a developmental delay or developmental disability: _____

Date of Birth: _____ Social Security Number: _____

Disability or Diagnosis: _____

Time of onset: Birth: Yes No If later, year: _____
Check: Ambulatory Non-Ambulatory

Financial statement: Indicate taxable annual income for prior year \$ _____

Private Insurance? Yes No Name/Policy Number: _____

Medicaid/Medicare Eligible? Yes No If yes, Medicaid/Medicare Number: _____

Bureau for Children with Medical Handicaps (BCMh) Eligible? Yes No

List any other funding sources available to the family member: _____

DOES THE FAMILY RESIDE IN DARKE COUNTY? Yes No

DOES THE FAMILY MEMBER WITH A DEVELOPMENTAL DELAY OR SUBSTANTIAL DEVELOPMENTAL DISABILITY RESIDE AT HOME WITH HIS OR HER FAMILY ON A FULL TIME BASIS? Yes No

IS THE FAMILY MEMBER CURRENTLY ENROLLED IN A DARKE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES PROGRAM?

Yes No **IF YES, IDENTIFY PROGRAM** _____

BOARD APPROVAL:

Community Services Director

Date

Business Manager

Date

Co-payment amount to be paid by Darke County Board of Developmental Disabilities: _____%

Co-payment amount to be paid by the individual: _____%

Date of written notification of eligibility: _____

Revised: 8/28/09