Ashtabula County Board of Developmental Disabilities

Enriching, empowering, and connecting people with their community

Family Support Services Program
Application for Services

Name of Individual:_____ Funding Year:_____

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: