



APPLICATION FOR FAMILY SUPPORT SERVICES

Parent/Guardian Name _____

Parent/Guardian Address (City/State/Zip): _____

Home Phone: _____ Work Phone: _____ Social Security Number: _____

Child/Consumer Name _____

Date of Birth _____ Social Security Number _____

Address (City/State/Zip) _____

Are you residents of Sandusky County? Yes No

Does the child/consumer reside in the family's home? Yes No

Does the child/consumer have a diagnosis of mental retardation or a developmental disability? Yes No

Does the child/consumer currently receive services from the Sandusky County Board of Mental Retardation and Developmental Disabilities? Yes No

If the family does not receive any services are you willing to undergo a screening conducted by the Sandusky County Board of Mental Retardation and Developmental Disabilities to determine eligibility for services? Yes No

Please check those services that you are interested in for your child/consumer:

___ Respite

___ Counseling, Training and Education for Family Members

___ Adaptive Equipment/Home Modifications As Prescribed by Medical Professional (including incontinence supplies)

___ Special Diet Items Prescribed by Doctor

___ Other _____

(including medical mileage, therapeutic activities for social and physical development and items for the health and safety that is related to child/consumer's disability)

Signature _____ Date _____

The family must complete this application and the income verification form at least yearly. Please complete and return forms to the designated Service and Support Administrator by JULY 1, 2009 Application - Family Support Services 09-10.

If you need assistance or have questions, please contact Megan Craun at (419) 332-9296, ext. 186