Adams County Board of Developmental Disabilities

SERVICE REQUEST FOR FAMILY SUPPORT SERVICES

Mail original form to: Adams CBDD, P.O. Box 157, West Union, OH 45693

APPLICANT INFORMATION		
Dependent Name:	Today's date:	
Name of person making request:		Phone:

TYPE OF SERVICES SEEKING		
Please check services you are interested in receiving if eligible:		
___ In-Home Respite	___ Adaptive Equipment	___ Training/Counseling
___ Out of Home Respite	___ Home Modification	___ Other
___ Emergency Respite	___ Special Dietary	
Have you tried other sources to fulfill this need?		
Please list other sources you have tried:		

RESPITE REQUESTS			
Date(s) you are requesting respite:			
Date: Hours:	Date: Hours:	Date: Hours:	Date: Hours:
Reason you are requesting respite?			
Do you need a provider Y or N?			
If no, who is your chosen provider?			
Address:		Phone:	

Note: All providers must be certified by ACBDD or have a Liability Form on file with the FSS program.

OTHER REQUESTS
Please use this space to describe your request:

SIGNATURE

I certify that the service(s) I am seeking is not covered by any other source including but not limited to Medicaid, waiver services, children services, etc. I further certify that if I have a co-pay I will make prompt payment to the appropriate person/agency. I understand if I misuse Family Support Service funds I may be penalized from future FSS funding.

Signature of agreement by responsible family member or guardian	Date:

ADMINISTRATIVE USE ONLY		
Approved:	Denied:	Co-pay:
Comments:		
Signature:	Date:	