PUTNAM COUNTY
BOARD OF DEVELOPMENTAL DISABILITIES

124 Putnam Parkway, Suite D, Ottawa, OH 45875
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www.putnamcountydd.com

Family Support Services – Application and Request for Funds

ALL requests must have prior approval BEFORE purchases are made

Name of Eligible Individual: _____

Birthdate:_____ Medicaid #:_____ Social Security #:_____

Name of Parent(s)/Family Member:_____

Email Address:_____

Special Equipment/Service Request

- Description:_____
- Professional recommendation from:_____
- Supplier/Provider:_____
- Estimated Cost:_____

Respite Services Request

- Number of hours/days:_____ Planned dates:_____
- Estimated cost ($6.25/hour, maximum of $75/day):_____
- Name of requested provider:_____

We are requesting the PCBDD to waive a background investigation for this provider. We are assured that this care is acceptable and provides for the safety and needs of our family, including all medical and transportation concerns. We assume all responsibility and liability for the selection of this provider.

Medical Mileage Request

- Location of expected medical travel:_____
- Total miles of expected travel:_____ Expected travel dates:_____
- Estimated Cost:_____

Other Request:_____

- Professional recommendation from:_____

Families should attempt to access other sources prior to Family Support Services. Family Support Services is the payee of last resort. If private insurance, BCMH, or JFS funding is available, they must be used before utilizing PCBDD funding. I verify that Family Support Services is being utilized as the Payer of Last Resort.

_____ _____

Parent/Guardian Signature Date