PUTNAM COUNTY
BOARD OF DEVELOPMENTAL DISABILITIES

124 Putnam Parkway, Suite D, Ottawa, OH 45875
Ph: 419-523-0122 ● Fax: 419-523-0121
www.putnamcountydd.com

Therapy Services Grant – 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:_____

Phone Number:_____

Type of Therapy Requested

- Description:_____
- Professional recommendation from:_____
    - Please attach a document with the professional recommendation
- Provider:_____
- Estimated Cost per month:_____

Families should attempt to access other sources prior to Therapy Services Grant Program. Therapy Services Grant Program 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 Therapy Services Grant Program is being utilized as the Payer of Last Resort.

_____ _____

Parent/Guardian Signature Date

Office Use Only

The applicant has been determined eligible for the Therapy Services Grant Program.

_____ _____

Initials of person verifying eligibility Date

Request Determination

_____ Date of request $_____Funds available for this request

_____ Date approved _____Date answer to family

_____ _____

Initials of Superintendent approval Date