

Family Support Services – Application and Request for Funds – 2026

ALL requests must have prior approval BEFORE purchases are made

****Send Requests to familysupport@putnamdd.org****

Name of Eligible Individual: _____
 Birthdate: _____ Medicaid #: _____ Social Security #: _____
 Name of Parent(s)/Family Member: _____
 Email Address: _____
 Phone Number: _____
 Mailing 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 payer 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

Office Use:

Recommend to: _____ Approve _____ Not Approve; Reason: _____

Signature of reviewer _____ Date _____