

**Therapy Service and Safety & Security Programs – 2026
Application and Request for Funds**

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: _____

Safety & Security Equipment or Service Request

- Assessed Need: _____
 - Please attach a document with the assessed need
- Description: _____
- Professional recommendation from: _____
- Supplier/Provider: _____
- Estimated Cost: _____
 - Please attach detailed information about the equipment/service requested

Therapy Request

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

****Families should attempt to access other sources prior to Putnam County Board of DD Programs. Putnam County Board of DD 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 the Putnam County Board of DD Program is being utilized as the Payer of Last Resort.**

Parent/Guardian Signature

Date

Office Use:

___ Assessed need verified ___ Waiver service ___ Payer of last resort

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

Signature of reviewer _____ Date _____