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

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 Family Member:____________________________________Relation to Individual:________________________

Email Address:______________________________

Phone Number:______________________________

Mailing Address:______________________________

Special Equipment/Service Request (Excluding Therapy)

- 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 – Calculated at the current IRS mileage rate

- Name of expected medical travel:______________________________
- Address/Location: ______________________________
- Total miles of expected travel:_________________________ Expected travel dates:____________________

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.**

______________________________ ______________________

Family Member Signature Date

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Office Use:

Recommend to: ____ Approve ____ Not Approve; Reason: ______________________________

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Signature of reviewer ___________________________________* Date ________________

*Signature confirms all requirements have been met as listed under Section 3.0 of PCBDD FSS Grant policies.