PAULDING COUNTY BOARD OF DD
FAMILY SUPPORT SERVICES
APPLICATION & ELIGIBILITY DETERMINATION
CALENDAR YEAR 2019

Name of applicant requesting financial assistance: _____

Address: _____ Ohio _____
Street City Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Applicant's relationship to individual(s): _____

Email address where information may be sent: _____

Name of person(s) with disability for whom daily care is provided:

Name: _____ Date of Birth: _____ Social Security #: _____-_____-_____

Name: _____ Date of Birth: _____ Social Security #: _____-_____-_____

Name: _____ Date of Birth: _____ Social Security #: _____-_____-_____

Complete the following:

A. Qualifying Individual(s)

The individual(s) for whom I/we provide daily care for:

1. Reside(s) at: _____
2. Currently attends:
   - □ Early Intervention Programs through the PCBDD
   - □ Preschool
   - □ Paulding County Schools
   - □ PC Workshop
   - □ Other: _____
3. If not currently in a day program, what was the last school or training program attended:
   _____
4. Is substantially developmentally disabled? Yes No
5. Did the disability occur before the age of 22? Yes No
6. Is dependent upon me/us for the majority of his her care? Yes No

B. Income Verification

Provide proof of ***2018 taxable income*** (located on tax return). If no tax return is available, indicate reason. If income for the current year is expected to be substantially different from last year, list expected taxable income and reason (i.e. loss of job, change in job). $_____

_____

_____

_____

OVER

C. Insurance Information

Is the person with a disability covered by insurance? Yes No

If yes, please complete the following:

Private Insurance Company Name: _____

Policy Holder: _____ Policy #: _____

Information below must be provided for each qualifying disabled person:

ODJFS Case Worker (if applicable): _____

Name: _____

Medicaid Yes No If yes, Medicaid Number _____

Medicare Yes No If yes, Medicare Number _____

Name: _____

Medicaid Yes No If yes, Medicaid Number _____

Medicare Yes No If yes, Medicare Number _____

Name: _____

Medicaid Yes No If yes, Medicaid Number _____

Medicare Yes No If yes, Medicare Number _____

[X} I, the undersigned, do hereby consent to allow the FSS Coordinator, and the Paulding County Board of DD to contact ODJFS or my insurance carrier to obtain information pertaining to my/our eligibility for services, including case/policy numbers, co-pay, and coverage dates. This consent will be valid from date of signing through December 31, 2019. I understand that I have the right to revoke this authorization at any time by sending or delivering such written notification to the FSS Coordinator at the Paulding County Board of DD, 900 Fairground Drive, Paulding, OH 45879.

D. Administrative Resolution of Complaints

[ ] I have received and read a copy of the Paulding County Board of DD Administrative Resolution of Complaints - this can be found in the Family Support Services brochure you received with this Application.

[ ] I have not received a copy of the Paulding County Board of DD Administrative Resolution of Complaints.

Applicant's Signature: _____ Date: _____

If you have questions completing this application, please contact the Family Support Services Coordinator at 419-399-4800