Southwestern Ohio Council of Governments (SWOCOG)
412 S. East St.
Lebanon, OH 45036
Phone (513) 559-6953, Fax (855) 763-3050
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VERIFICATION OF NEED FORM /FUNDING REQUEST (FSSP) 2026

Name of person enrolled:_____ Date: _____

Address:_____ Phone: _____

DOB _____ County: HAMILTON

Contact person:_____ Phone: _____

Email address: _____

If the check or voucher is to be sent to someone other than the family, please indicate here:

_____

Type of item(s) requested and how it will help

We will also need a printed price quote from the provider for equipment purchases or home modifications that list the name and address of the provider, the item or modification needed, and the total cost with this form including taxes, shipping and handling fees.

Please indicate if you would like to have this request handled as a reimbursement Yes☐ No ☐
*****Do not purchase any item until you have been notified by FSSP that the item has been approved*****

If item is not to be handled as a reimbursement, the request will be processed according to your county guidelines. If a check is issued, you are REQUIRED to provide a receipt to verify funds were spent appropriately.

Individual/Family signature: _____

Name of person enrolled: _____

County: HAMILTON

The mission of the Southwestern Ohio Council of Governments is to provide support and solutions to county boards of developmental disabilities through cost-effective shared services that deliver value, satisfaction, and maximization of resources.

This section to be completed by the professional recommending the item(s) requested. A therapist or DS must verify the need for adaptive, sensory or therapeutic items as well as home modifications. A doctor or therapist must verify the need for incontinence or nutrition supplies. All other items can be verified by any DD professional.

Professional's name: _____ Title: _____

Address: _____ Phone: _____

Email: _____

Signature: _____

Statement of why service/item is needed and how it relates to the persons disability. (If requesting an iPad, computer, or laptop, the item must meet an assessed need; can be functionally utilized by the individual with the disability making the request; is not for the purpose of meeting an educational need or service as required by the IEP. An iPad, computer, or laptop will only be considered for individuals age twelve and older in Hamilton County, unless an SLP recommends an IPad as a speech device.)

The section to be completed by a county board of developmental disabilities representative only.

Representative's name: _____

Title: _____

Signature: _____

Date: _____