WARREN COUNTY BOARD OF DEVELOPMENTAL DISABLITIES
FAMILY SUPPORT
410 S. East Street Lebanon, OH 45036
Email: Familysupport@warrencountydd.org

FAMILY SUPPORT REQUEST FOR SERVICES FORM

PLEASE SUBMIT YOUR REQUEST 15 DAYS PRIOR TO WHEN YOU WOULD LIKE THE SERVICES TO BEGIN TO GIVE TIME TO REVIEW (This is not an approval)

ONCE A REQUEST IS APPROVED, YOU WILL RECEIVE VOUCHERS

IF WE ARE REIMBURSING YOU, WE NEED A COMPLETED W-9 ON FILE

INDIVIDUAL ENROLLED: _____

PARENT/GUARDIAN: _____

EMAIL: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

WHO IS TO BE PAID: _____

SIGNATURE: _____

DATE: _____

☐ **DISPOSABLE ITEMS (DIAPERS/SUPPLEMENTAL NUTRITIONAL ITEMS OVER THE AGE OF 3)**

(A letter of need will need to be provided (on page 4) from the professional recommending the items. Please indicate how the requested item(s) will benefit the individual due to their needs)

ITEM(S) NEEDED:

COST PER MONTH: _____

☐ **HOME MODIFICATION MINOR (ATTACH CONTRACTORS BID FOR SERVICES)**

(A letter of need will need to be provided (on page 4) from the professional recommending the items. Please indicate how the requested item(s) will benefit the individual due to their needs)

MODIFICATION NEEDS REQUESTED:

CURRENTLY: **OWN YOUR HOME** ☐ **RENTING** **IN THE PROCESS OF BUYING**

☐ **THERAPY**

NO LETTER FROM A PROFESSIONAL IS NEEDED FOR THERAPY

TYPE OF THERAPY/THERAPIES NEEDED

COST PER MONTH: _____

☐ **ADAPTIVE EQUIPMENT: For all items requested, please include Vendor Name, Item Number, and the Cost of Items. Please complete all of the information for requested items or this can delay the process. (Limit 5 Items Per Month and only 2 Items for the same purpose)**

(A letter of need will need to be provided (on page 4) from the professional recommending the items. Please indicate how the requested item(s) will benefit the individual due to their needs)

Professional Recommendation

Individual Enrolled _____ **Date of Birth** _____

Professional Recommending the Items: _____

Professional Licensure: _____

Email: _____ **Phone:** _____

The following recommendation is being made regarding an Adaptive Equipment Request for the above enrolled Individual.

VENDOR	ITEM #	DESCRIPTION	PRICE	QUANTITY

IF YOU HAVE ADDITIONAL NEEDS THAT ARE NOT DEFINED, PLEASE CONTACT: SANDY SCHUTTE
EMAIL: Familysupport@warrencountydd.org

Professional Letter of Need: (Indicate how the requested item(s) will benefit the individual due to their needs) Please understand we do our best to accommodate requested items but this isn't a guarantee that items will be approved

Signature: _____

Date: _____