

LICKING COUNTY

— Board of —

DEVELOPMENTAL DISABILITIES

Application

Applicant Name: _____
Last
First
Middle
Maiden (if applicable)

Date of Birth: _____ Age: _____ Male Female Hispanic/Latino Non-Hispanic/Latino

Race: Caucasian African-American American Indian/Alaskan Native Asian Native Hawaiian & Pacific Islander

Address: _____
Street Address
City
Zip

Phone Number Home: _____ Cell: _____ Other: _____

Email (if over 18): _____ *We do not share your email information; we use it solely to communicate important information regarding the supports you receive from us.*

Family Contact Information:

Mother or Other (Relationship _____) Name: _____

Address Same as Applicant
 Or Write Other Address Here: _____
Street Address
City
Zip

Phone Number Home: _____ Cell: _____ Other: _____

Email: _____ *We do not share your email information; we use it solely to communicate important information regarding the supports you receive from us.*



Father or Other (Relationship _____) Name: _____

Address Same as Applicant
 Or Write Other Address Here: _____
Street Address
City
Zip

Phone Number Home: _____ Cell: _____ Other: _____

Email: _____ *We do not share your email information; we use it solely to communicate important information regarding the supports you receive from us.*

Legal Guardian: _____

Address Same as Applicant
 Address: _____
Street Address
City
Zip

Phone Number Home: _____ Cell: _____ Other: _____

Email: _____ *We do not share your email information; we use it solely to communicate important information regarding the supports you receive from us.*

For Staff Use Only:

- | | |
|--|---|
| <input type="checkbox"/> Enter into Gatekeeper as <input type="checkbox"/> Applicant or <input type="checkbox"/> Resource and Referral | <input type="checkbox"/> Email to ESW to follow up for file check |
| <input type="checkbox"/> Sent out Information | <input type="checkbox"/> Check IDS |

Have you applied for and/or received services from Licking or any other County Board?

Yes No If Yes, where and for how long? _____

How did you hear about us? _____

What prompted you to call? What kind of help do you need?

Schools attended/types of classes:

Agencies involved with:

Diagnoses:

Employment:

Additional Information:

Name of Person Making Referral: _____ Relationship: _____ Phone: _____

Received by: _____ Date: _____