LICKING COUNTY
— Board of —
DEVELOPMENTAL DISABILITIES

2017 Request for Family Support Services Funds

Name of eligible child
Or adult person: _____ Age: _____

The name and ages of eligible sibling(s): _____ Age(s): _____

Your son/daughter/family member's
service coordinator: _____

The name and mailing address and phone number of the parent/guardian who will receive the FSS payment:

Name: _____

Address: _____

Phone: _____

City/Zip: _____

Is your son or daughter enrolled in any of the following:

- ☐ Medicaid Managed Care Plan
- ☐ Health Check
- ☐ Individual options Waiver
- ☐ Level One Waiver
- ☐ Transitions Waiver
- ☐ Ohio Home Care Waiver
- ☐ Passport Waiver
- ☐ SELF Waiver

Please sign your name verifying that the information on this application is accurate and correct:

_____ _____
Signature Date

The Family Support Services Information Sheet lists examples of allowable FSS expenditures. It has additional information about the process of requesting funds and approval. Please review that sheet before requesting funds from FSS.

FSS Funds to be used for:

Specific Item or Service needed:	Who will be using this item or Service:	Anticipated Cost:	Service Coordinator Recommendation (Circle one)
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

_____ _____
Service Coordinator Review and Approval Date

If you intend to use any portion of Family Support Services (FSS) funding on respite, please complete the FSS respite Acknowledgement Form and return it with this application. Instructions on back.

LICKING COUNTY
Board of
DEVELOPMENTAL DISABILITIES

Return this form to:

Your Service Coordinator via Email,

Or Fax (740)349-1426

Or mail to:

LCBDD Service Coordination

Attn: (*Put your Service Coordinator's name here*)

565 Industrial Parkway

Heath, OH 43056