

Application for Family Support Services

Date_____

Applicant's Name_____ Sex M F

Social Security #_____ Date of Birth_____

Parent/Guardian Name (relationship to applicant)_____

Home Address_____

Phone Number_____

Is the applicant a resident of Geauga County? _____ Yes _____ No

Is the applicant living in a foster home? _____ Yes _____ No

Are there other persons living in the home who have mental retardation and/or developmental disabilities? _____ Yes _____ No

If yes, please list names and ages:_____

HEALTH INSURANCE INFORMATION:

Name of Insurance Company_____

Policy Holder:_____

Group # _____ ID # _____

Medicaid # _____ BCMH # _____

Medicare # _____ Other _____

(Please Complete Back)

Applicant's Educational or Employment Setting (including sheltered workshop):

Name and Address _____

Health and Medical Status:

Present Diagnosis and year diagnosed: _____

Does the applicant require special services for potential life-threatening emergencies?
(i.e. respiratory failure, heart failure, seizures, etc.) Please
describe _____

Please give any other information that might be helpful to assess the needs of the
family.

Are you related to a former or current board member or employee of the Geauga
County Board of MR/DD? _____ Yes _____ No (If yes, your request will be
approved by the Ethics Council at the next Board Meeting. (Per ORC)

Services Requested:

In-home respite _____ Out-of-home respite _____ Home modification _____
Dietary needs _____ Incontinence garments (diapers, pull-ups, liners, etc.) _____
Counseling/training/seminars _____
Adaptive equipment (wheelchair, bathchair, special lift, etc.) _____
Other _____

Parent/Guardian signature

Date

Please return to:

Family Support Services
8200 Cedar Road
Chesterland, Ohio 44026
440-729-9406