



SANDUSKY COUNTY BOARD OF DEVELOPMENTAL DISABILITIES FAMILY SUPPORT SERVICES – SERVICE REQUEST FORM

Eligible Child or Children’s Name(s): _____

Name of Parent/Guardian: _____

Street Address (City, State, Zip): _____

PHONE: _____ E-Mail: _____

What Quarter are services being requested for:

1st Quarter
Jan-Feb-Mar

2nd Quarter
Apr-May-June

3rd Quarter
July-Aug-Sept

4th Quarter
Oct-Nov-Dec

Type of Service Requested: (please check all services being requested)

Respite Care Services (*Need Non-Certified Provider form and Assurance Form) /**Medical Co-Pay:**

Date Services Requested: From: _____ To: _____
(Date/Time) (Date/Time)

Hourly Rate (\$) Requested for Respite Payment: _____

How many hours: _____

= Amount (\$): _____

Counseling, Training, or Educational Service:

Service: _____

= Amount (\$): _____

Special Diet:

Brief Description: _____ (A specialist order, letter, or signature must be included)

= Amount (\$): _____

Incontinence Supplies:

Brief Description: _____ (A specialist order, letter, or signature must be included)

= Amount (\$): _____

Adaptive, or Specialized Equipment, or Home Modification:

Brief Description: _____

= Amount (\$): _____

Medical Mileage:

Brief Description: _____

= Amount (\$): _____

Total Estimated Amount of services/Items requested for Quarter:

= Total Amount (\$): _____

Estimate high to cover the cost of any shipping/taxes, which are included in your family’s yearly allocation.



Explanation. Briefly state why the above item or service is needed: _____

Family Member Reimbursements: complete this section only if a family member is to be reimbursed

Name of family member to be reimbursed: _____

Family members relationship to child: _____

Street Address (City, State, Zip): _____

Phone Number: _____

Non-Family Member or Vendor: Complete this section if a company or non-family member will be paid or requesting SCBDD to order supplies directly. *This could be a doctor, counselor, camp, therapy provider, adaptive equipment company, contractor, incontinence supply company, Therapeutic Horseback Riding provider, or a Respite Provider that is not family.*

Please check if SCBDD will be ordering this item

Service/Vendor Name: _____

Address (city, state, zip): _____

Phone: _____

Adaptive Equipment and Home Modification: Please list the specific items requested, item numbers, cost of each item, and where the item is to be purchased. _____

Specialists: If a physician, dietician, or therapist has recommended an item or service for you, a written order on the professional's prescription pad is satisfactory OR have the professional complete the section below.

Service/Vendor Name: _____

Address (city, state, zip): _____

Phone: _____

Signature & Date: _____

Sign and return to Sandusky County Board of DD for approval. You will receive a response form indicating if your request has been approved/denied.

I have exhausted all other sources of funding for the requested items or service and understand that items or services cannot be rendered prior to approval confirmation received.

Signature _____

Date: _____