



Request Form for Eligibility Determination and Services

Referrals must be made by individual seeking services, their parent, or their legal guardian

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

eMail Address (optional): \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

eMail Address (optional): \_\_\_\_\_ Phone: \_\_\_\_\_

Has the individual received services from Sandusky County Board of DD in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

What is the nature of the individual's disability? Other pertinent information you would like to share?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Request Form Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Internal Use Only

Intake Coordinator Signature: \_\_\_\_\_

Date received: \_\_\_\_\_

Eligible: \_\_\_\_\_ Not Eligible \_\_\_\_\_ Date Determined \_\_\_\_\_

- Service & Support Administration Residential Options Family Support Services
Waiver Service Special Olympics Community Employment

Eligibility confirmation letter sent: \_\_\_\_\_ Denial letter and due process sent: \_\_\_\_\_ IDS: \_\_\_\_\_

Referred to: \_\_\_\_\_

for ages 3-5 only \_\_\_\_\_ (Superintendent)