FAMILY SUPPORT SERVICES PROGRAM
Ashtabula County Board of DD
500 W. Main St.
Geneva, OH 44041
Phone: (440) 466-7110 Fax: (440) 466-7047

Application For Services

Date_____

Dependent Name _____Birthdate_____/_____/_____

Parent/Guardian_____

Address_____Ohio_____
Street City State Zip

Are you currently living in an ICF/MR? Yes _____ No _____

Home Phone #_(_____)_____ Work: Mother_____
Father _____

In Case of Emergency Contact_____

Relationship_____Phone _____

Referred to Family Support Services by _____

Type of Service Requested:

In-home respite _____ Out-of-home respite _____
Camp _____ Other _____

Provider Information

I would like assistance in selecting a provider: yes_____ no_____
I have designated a provider. Please complete this section:

Provider's Name_____

Address_____

Home Phone_____Work Phone_____

Families selecting their own provider must complete the **Waiver of Provider Training** form of the application packet.

Parent/Guardian Signature_____Date_____

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FAMILY SUPPORT SERVICES PROGRAM
FAMILY INCOME CERTIFICATION FORM

This form must be completed when enrolling for the program.

Client's Name_____

Parent/Guardian Name_____

I hereby certify that our taxable yearly income for _____(prior year) is: _____

Filed jointly_____ separately_____

The amount of the taxable income for the household was _____(see taxable income line on your income tax form). Please list both incomes if you are married and file separately.

Your family may have a co-pay for services depending on the annual taxable income for you household. Please refer to the Family Support Service brochure for more information.

Thank you for providing this information. This confidential information is required by the State of Ohio for the Family Support Service Program. This information will be updated annually.

Signature_____Date_____