Application for Services

Please fill out as completely as possible (Please Print)

Last Name: _____ First Name: _____ Middle: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ SSN: _____

Hair Color: _____ Eye Color: _____ Race: _____

Ethnicity:_____ Primary Language: _____ Secondary Language: _____

Cultural Considerations: _____

_____

Mother's Name:_____

Address: _____

Email: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Father's Name: _____

Address: _____

Email: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Parents: ☐Married ☐Single

Applicant Lives: ☐With both parents ☐Independently
☐With Mother ☐With Father
☐Other: _____

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School District of Residence/Attendance: _____

Graduation/Expected Graduation Date: _____

Does the applicant have a current individual education plan (IEP) ☐ Yes ☐ No ☐ N/A

Does the applicant have an Evauation Team Report (ETR)/Multi-Functional Evaluation (MFE)
☐ Yes ☐ No ☐ N/A

Does the applicant have any of the following?
☐ Legal Guardian ☐ Power of Attorney ☐ Custodial Parent

If checked above, please provide the following:

Name of Guardian: _____ Legal Guardian Docket #: _____

Address: _____

Email: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Service Information

Has the applicant recieved services from another County Board of DD?
☐ Yes If Yes, What County?_____ ☐ No

Name of the applicant's Service and Support Administrator (SSA) in that county: _____

Please describe the services and include dates of service: _____

Services being requested from the Portage County Board of DD: _____

_____

_____

_____

Medical Information

Primary Physician or Clinic: _____

Address: _____

Phone: _____

Consulting Physicians: (e.g. Neurologist, Cardiologist, Orthopedist, Opthmologist, etc.)

Name: _____ Phone: _____

Name: _____ Phone:_____

Name: _____ Phone: _____

Medical Health Agencies (CSS, Portage Path): _____

Who orginally diagosed the applicant with a developmental disability? _____

List the diagnosis and date: _____

Does applicant have any mental health involvement/diagnosis? ☐ Yes ☐ No

If yes, please list the diagnosis: _____

Who provided the diagnosis?: _____

How is the diagnosis manifested? (e.g. what does the applicant do or not do?: _____

_____

_____

Please list any medical conditions or limitations that may affect the applicant's services (e.g. low vision, wheelchair, etc):

_____

_____

List medications that the applicant is taking: _____

_____

Developmental History

Were there any unusal circumstances during the applicant's birth? _____

_____

Was the applicant born prematurely? ☐ Yes ☐ No

If yes, how early: _____

Were there any complications after the applicant's birth? ☐ Yes ☐ No

If yes, please describe: _____

_____

Social History

Language spoken/understood: _____

Other current service providers (if any): _____

_____

Previous service providers: _____

_____

Financial History

MEDICAID of Ohio Medicaid Care Plan Name: _____

Billing #: _____

MEDICARE #: _____

BCMH: _____

Other: _____

_____

Family Information

Father's birth date: _____ Deceased? ☐ Yes ☐ No

Occupation: _____

Employer: _____ Phone Number: _____

Mother's birth date: _____ Deceased? ☐ Yes ☐ No

Occupation: _____

Employer: _____ Phone Number: _____

Please list family members and others living in the home:

Name	Birth Date	Relationship	School/Occupation

Additional Information:

Other important facts that should be considered when determining eligibility (e.g. previous service providers, family history, treatment history, legal, children services, juvenile detention center, etc.):

Portage County Board of DD Information:

Please check all that apply:

- ☐ I have recieved a copy of the Portage County DD Due Process brochure.
- ☐ I have received a copy of of the Portage County DD Privacy Practices brochure.
- ☐ I give Portage County DD staff member's permission to complete appropriate and necessary evaluations in order to determine eligibility (e.g. C/COEDI, therapy assessments, etc).

The Portage County Board of Developmental Disabilities is a designated agency for voter reistration. If you are not already registered to vote, or if you are currently registered to vote and want to update your registration, you may do so at 2606 Brady Lake Rd, Ravenna, Ohio 44266. If you need help filling out the form, a Portage County DD staff will assist you. Registering (or not registering) to vote has no bearing on the availability of services or eligibility. The Voter Registration Agency Coordinator for Portage County DD can be reached at 330-297-4100.

Would you like Portage County Board of DD staff to assist you with registering to vote?

☐ Yes ☐ No

Please check one:

☐ Self/Applicant ☐ Parent of applicant who is under 18 years of age

☐ Legal Guardian ☐ Custodian or Custodial Parent

Name of Person-Served	Signature of Person-Served	Date

Name of Parent/Guardian	Signature of Parent/Guardian	Date

If you have any questions while filling out the Intake Packet please reach out to the Intake Department at (330-297-4101).

Authorization For Release of Confidential Information

Name of Person-Served: _____ Date of Birth: _____

I authorize The Portage County Board of Developmental Disabilities (Portage DD) to:

Release to: _____ Address: _____

The Following Information:

- ☐ Assessment and diagnosis
- ☐ Individual Service Plan
- ☐ Functional Assessment
- ☐ FED
- ☐ Social History
- ☐ Other: _____

Obtain from: _____ Address: _____

The Following Information:

- ☐ Assessment and diagnosis (MFE)
- ☐ Treatment and progress notes
- ☐ Psychological test results
- ☐ Most current IP (ISP,IEP,IHP)
- ☐ Results of recent physical examination
- ☐ FED
- ☐ C/OEDI
- ☐ Other: _____

The purpose of this disclosure is:

- ☐ Coordination of Care
- ☐ Requested by Person-Served or Guardian/Parent
- ☐ Other: _____

1. I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.

2. I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.

3. The Portage DD does not require that I sign this authorization in order to receive services.

Signature: _____ Date: _____

Print Name: _____

Authority to sign:

- ☐ Appointed by Individual as HIPAA Personal Representative
- ☐ Parent or Guardian
- ☐ Chosen Representative per SSA Rule
- ☐ Other: _____

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Billing Verification Sheet

Please Complete All Information

Name: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____ Social Security Number: _____

Gender: _____

Check One: ☐ I have Medicaid Medicaid Number is: _____
☐ I have Medicare Medicare Number is: _____
☐ I do not have Medicaid or Medicare insurance coverage

Check One: ☐ I do not have insurance coverage (other than Medicaid or Medicare)
☐ I do have insurance coverage (complete the information below)

Primary Insurance

Insurance Plan Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Insured Name: _____

Policy Number: _____ Group/ID/Company Number:_____

Secondary Insurance

Insurance Plan Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Insured Name: _____

Policy Number: _____ Group/ID/Company Number:_____

By signing this form, I authorize the release of any medical or other information necessary to process my insurance claim. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to provide the Portage County Board of Developmental Disabilities with any changes to my health insurance coverage.

Name of Person-Served	Signature of Person-Served	Date

Name of Parent/Guardian	Signature of Parent/Guardian	Date

Confidentiality Notice

This form is intended for the addressee shown above. It may contain information that is privileged, Confidential or otherwise protected from disclosure and is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any review, use, dissemination distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone at 330-297-6209 or by the address above and destroy the message as well as any copies. Thank you.

Additional Information

This is the additional information below that needs to be submitted along with the application packet.

Evaluation from medical doctor with diagnoses-if autism diagnosis need actually evaluation with Autism Diagnostic Observation Schedule (ADOS) scores, cannot use a letter from doctor.

- ☐ A copy of guardianship paperwork (as applicable)
- ☐ A current copy of the Evaluation Team Report (ETR) from the school
- ☐ A current copy of IEP from the school
- ☐ A copy of the birth certificate
- ☐ A copy of the social security card
- ☐ A copy of the Medicaid card (as applicable)