



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: _____



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 Evaluation 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 originally diagnosed 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 unusual 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 received a copy of the Portage County DD Due Process brochure.
- I have received a copy 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: _____



Authorization For Release of Confidential Information

For staff use: (complete the following steps and indicate by a check)

Name of Person: _____

- Copy of signed authorization given to Individual/Parent/Guardian
- Copy of records released given to Individual/Parent/Guardian (If Requested)
- Disclosure logged on Disclosure Log

Revocation received on _____ and acted upon.



Billing Verification Sheet

Please Complete All Information

Name: _____ Gender: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Social Security Number: _____

Check One: I have Medicaid Medicaid Number is: _____

Check One: I have a managed care plan under Medicaid (if so, list care provider):

Check One: 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: _____

