

REQUEST FOR FAMILY RESOURCE SERVICES
Coshocton County Board of Mental Retardation/Developmental Disabilities
23720 Airport Road
Coshocton, OH 43812
(740) 622-2032

NAME OF CHILD/ADULT: _____ DATE OF BIRTH: _____

NAME OF PARENTS/CARETAKERS _____

ADDRESS OF RESIDENCE: _____

MAIL ADDRESS IF DIFFERENT: _____ PHONE: _____

SOCIAL SECURITY NUMBER: _____ WORK PHONE: _____

SUMMARIZE DIAGNOSIS/LIMITATIONS: _____

PLEASE INDICATE THE APPROPRIATE ATTENDANCE OF CHILD/ADULT:

_____ HOPEWELL SCHOOL _____ EARLY INTERVENTION
_____ ADULT SERVICES _____ CASE MANAGEMENT ONLY
_____ PUBLIC SCHOOL _____ OTHER _____

SERVICE(S) REQUESTED: RESPITE CARE _____ SPECIAL DIET _____
ADAPTIVE EQUIPMENT _____ HOME MODIFICATION _____
COUNSELING/TRAINING/EDUCATION _____ OTHER SERVICES _____

PLEASE STATE WHY YOU ARE REQUESTING THE SERVICE(S) ABOVE. INDICATE OTHER RESOURCES UTILIZED OR APPLIED FOR PRIOR TO APPLYING FOR FAMILY RESOURCE SERVICES. IF YOU HAVE INSURANCE OR ARE ELIGIBLE FOR MEDICAID OR BCMH YOU MUST USE THESE PAYMENT SOURCES FIRST BEFORE YOU REQUEST FAMILY RESOURCE MONIES.

PLEASE INDICATE IF A PERSON, PROFESSIONAL, OR AGENCY REFERRED YOU TO THE PROGRAM FOR A SPECIFIC REQUEST: _____

IF YOU ARE REQUESTING FUNDING FOR EQUIPMENT OR SPECIAL DIETS YOU MUST HAVE A PRESCRIPTION OR WRITTEN RECOMMENDATION FROM A PHYSICIAN OR THERAPIST. ALSO SUBMIT QUOTES, CATALOGS OR VENDORS WHERE THE SERVICES ARE AVAILABLE.

SIGNATURE OF PARENT/CARETAKER
FRS:002

RELATIONSHIP TO APPLICANT

DATE