Erie County Board of Developmental Disabilities
Application for Services
Address: 4405 Galloway Rd, Sandusky, Ohio 44870; Phone: 419/626-0208

Applicant Name (last, first, middle):____**DOB:**_______________

Address:____**City/State/Zip:**__________________________

Phone:______________________**Cell:**________________________**Work:**_____________________________

Email: ____

Social Security #:___________________ **Sex:** M F

Race (circle one): White, Black, Hispanic, Indian/Alaskan, Asian/Pacific, Other

Ethnicity (circle one): Hispanic/Latino or non-Hispanic/Latino

Medical Insurance:____ **Policy #**:__________________________

Contact Person (Parent/Guardian/Self): circle one____

Address:____**Email**: ____________________________

Phone (H): ______________________**(W)**:________________________ **(Cell)**:_________________________

Referral Source Name:______________________________________**Agency:**____________________________

Address:____

Phone (W): ____________________**(Cell)**:_____________________**Email:**______________________________

School District Attended:_____________________________ **Currently in School:** **Yes** ☐ **No** ☐

Currently receiving a waiver: ☐ **Level One** ☐ **IO** ☐ **Self** ☐ **None**

Primary Care Physician: ____ **Phone**: _______________________

Address:____

Disability/Need/Concern:____

☐ Initial Eligibility for DD services -request for an OEDI or COEDI assessment

☐ Redetermination – has previously received Board services/documents attached

☐ Request to Restart Services – explain on back side why requesting to start services again

My signature below indicates my request for eligibility and services with the Erie County Board of Developmental Disabilities. I reviewed this application for accuracy of information.

____

Applicant / Guardian Signature **Date**

Revised 1/2020

Consent to Release Information

4405 Galloway Road
Sandusky, Ohio 44870
Phone: (419) 626-0208
Fax: (419) 621-3968, (419) 621-3971

____
Full Legal Name of Individual

_______________ _______________
Birth Year SSN#

I. I authorize the Erie County Board of DD to obtain from, release to, and exchange information with the following agencies:

- ☐ Erie County Health Department
- ☐ Firelands Mental Health
- ☐ North Point ESC
- ☐ Social Security Administration
- ☐ Ohio Dept. of DD
- ☐ Bayshore Counseling
- ☐ Erie County Dept. of Jobs & Family Services
- ☐ Help Me Grow
- ☐ School District (specify) ______________
- ☐ Clearwater COG
- ☐ Service Provider (specify) ______________________________
- ☐ Service Provider (specify) ______________________________
- ☐ Physician (specify) ______________________________
- ☐ Physician (specify) ______________________________
- ☐ Other (specify) ______________________________
- ☐ Other (specify) ______________________________

II. The information to be disclosed consists of:

- ☐ Birth Certificate
- ☐ Immunization Record
- ☐ Medical / Psychological Evaluation
- ☐ Evaluation Team Report
- ☐ Progress Report(s)
- ☐ Social Security Card / Number
- ☐ Custody Papers
- ☐ Proof of Eligibility / FED form
- ☐ Individual Plan (IFSP, IEP, ISP, etc.)
- ☐ Behavior Support Plan / Documentation
- ☐ Other (specify) ______________________________
- ☐ Other (specify) ______________________________

III. This information will be used for the following purpose(s):

- ☐ Determine Eligibility for DD Services
- ☐ Medical Evaluation and Treatment
- ☐ Assessment / Evaluation
- ☐ Program Planning
- ☐ Implementation of Service(s) and Support(s)
- ☐ Other (specify) ______________________________
- ☐ Other (specify) ______________________________

This authorization will expire on (date) or after sixty (60) days from the signed date of consent if noexpiration date is specified. I understand that I may revoke this authorization at any time by submittingwritten notice of the withdrawal of my consent. I recognize that health records, once received by aschool district, may not be protected by the HIPAA Privacy Rule, but will become educational recordsprotected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign,such refusal will not interfere with the ability to obtain health care and/or services.

______________________________ ______________
Individual / Parent / Guardian **Date**

______________________________ ______________
Witness (if applicable) **Date**