Erie County Board of Developmental Disabilities

Application for Services

Address: 4405 Galloway Rd, Sandusky, Ohio 44870; Phone: 419/626-0208
Email to: ssberna@eriecbdd.org

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 ☐ non-Hispanic/Latino

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: _____

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

☐ Redetermination – has previously received Board services.

☐ Request to Restart Services

Explain Need/Concern: _____

_____

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**

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

Last 4 of 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
- ☐ Service Provider (specify) _____
- ☐ Service Provider (specify) _____
- ☑ Physician (specify) _____
- ☑ Physician (specify) _____
- ☐ Other (specify) _____
- ☐ Other (specify) _____
- ☐ Bayshore Counseling
- ☑ Erie County Dept. of Jobs & Family Services
- ☐ Help Me Grow
- ☑ School District (specify) _____
- ☑ COG

II. The information to be disclosed consists of:

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

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 no expiration date is specified. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by a school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected 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