

Date \_\_\_\_\_ Consumer Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ City \_\_\_\_\_

Email \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other family members eligible?  Yes  No If yes, please include name, age, diagnosis:

Type of Insurance - please select  Private Insurance  Medicaid  Medicare

Funding Sources - please mark if consumer has:

Level 1 Waiver  Individual Options Waiver  Other Financial Support through LCBDD

Ohio Home Care Waiver

Name of School \_\_\_\_\_ LCBDD Specialist (SASS, EIS) \_\_\_\_\_

Therapy Services - please mark if consumer is receiving:

Occupational Therapy (OT)  Physical Therapy (PT)  Speech Therapy (SP)

Therapist Name \_\_\_\_\_ Service Location \_\_\_\_\_

Please select below your **household taxable income** (your income minus deductions). If there is a change in the family income during the year, please contact Family Support to update your family contribution percent.

Family Taxable Income	Percentage of Family Contribution	Verification of Income
<input type="checkbox"/> \$0 to 27,258	0%	<input type="checkbox"/> In file
<input type="checkbox"/> \$27,259 to \$37,759	10%	<input type="checkbox"/> LCBDD Staff _____ initials
<input type="checkbox"/> \$37,760 to \$48,260	30%	
<input type="checkbox"/> \$48,261 to \$62,261	50%	
<input type="checkbox"/> \$62,262 to \$79,762	75%	
<input type="checkbox"/> \$79,763 and Over	100%	

Request a form emailed or mailed:  Respite Form  Receipt Form

All forms can be found at [www.lucasdd.org](http://www.lucasdd.org) (Look for Family Support Services Program within the Services & Supports tab)

I hereby certify that the information I have provided is true to the best of my knowledge. **I understand and acknowledge** that the total cost of services is reimbursed within the current funding limit and in accordance with the family's taxable income level and in accordance with the guidelines. The funds are not guaranteed and requests need to be **submitted within 30 days of service/purchase**. All vouchers must be submitted and postmarked by October 31, 2022.

\_\_\_\_\_  
Parent/Guardian Signature Date

Mail to:  
 Family Support Services  
 c/o Lucas County Board of Developmental Disabilities  
 1154 Larc Lane  
 Toledo OH 43614

Staff Signature

Call Vicky Lambert with any questions, at 419-381-6139.