

Date _____

Client Name _____ Parent/Guardian Signature _____

Address _____

City _____ State _____ Zip _____

Professional Recommendation

Professional Name & Title _____

ORDER REQUESTED INFORMATION: *Please attach printout information to ensure correct items are ordered.*

Company	Phone #	Item#	Description (color,size)	PRICE

Family support Services
Contact and Submission Information
Phone: 419-381-6319
Lucas County Board of Developmental Disabilities
1932 Birchwood, Toledo, OH 43614
VLambert@lucasdd.org
Fax: 419-380-2610

OFFICE USE ONLY	
Funds Available \$ _____	Sub-Total _____
Family Co-Pay% _____	Shipping _____
	Total _____
Contract # _____	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
	Date _____