Crawford County Board of DD
1630 East Southern Ave
Bucyrus, OH 44820
www. crawfordcbdd.org

APPLICATION FOR SERVICES

Date					
Applicant Name					
Applicant Social Security #		Applicant's Date of Birth			
Applicant Address/City/Zip					
Applicant Phone		Cell		E-Mail	
Applicant Medicaid MMIS #		Applicant Medicare #			
Applicant Other Medical Insurance					
Emergency Contact Person		Relationship			
Address/City/State/Zip		Phone/Cell			
Name of Legal Guardian		Phone/Cell			
Address/City/State/Zip					

SOCIAL HISTORY

Parent Name		Date of Birth			
Address					
Phone		Email Address		Employment	
Parent Name		Date of Birth			
Address					
Phone		Email Address		Employment	

NEEDS & SERVICES

What are your current needs/services requested?

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Medical History of Applicant

Current Services: * please mark if currently receiving

☐	Occupational Therapy (OT)	☐	Physical Therapy (PT)	☐	Speech Therapy (SP)
☐	State Plan Nursing	☐	State Plan Aide	☐	State Plan Private Duty Nursing
☐	Ohio Rise / Harbor	☐	Family and Children First Council (FCFC)	☐	OOD/ Employment
☐	Probation	☐	Children Services	☐	Help Me Grow / Early Intervention

Other Agency/Agencies	
Mental Health:	
Doctor(s)	
Specialist (s)	

School History:

School District:	Grade Level
District of Residence:	IEP / 504 ☐ Yes ☐ No

My preferred method of communication: *Please select all applicable methods.

☐	Regular Mail	☐	E-Mail	☐	Phone
☐	Text	☐	Video Conference		

Signature of Applicant / Legal Guardian (Age 18+):	**Signature of Parent/Guardian if Applicant is a Minor:**

FOR INTERNAL USE ONLY Date DX verified: _____-_____-_____

Initial Determination/Redetermination ☐ COEDI – OR – ☐ OEDI Is this an appeal? ☐YES ☐NO

Received: ☐ Medicaid / Insurance Card (☐ check if not applicable or needed) ☐ Birth Certificate ☐ Social Security Card

☐ Formal Diagnosis ☐ Court Documentation ☐ IEP/ 504 (☐ check if not applicable or needed)

NOTES: _____

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