Fayette County Board of
Developmental Disabilities

Fayette County Board of Developmental Disabilities

1330 Robinson Road
Washington Court House, Ohio 43160
(740) 335-7453
Fax (740) 335-2185

TO:

FROM: Melissa Johnson
Intake/Eligibility Specialist

Please find enclosed an Application for Eligibility, and an Authorization to Release Records to be completed by you to determine if you are eligible for services from the Fayette County Board of DD.

Application for Eligibility:

1) You will notice several services at the top of the form that are provided by the Fayette County Board of DD, check the areas that may interest you.
2) ***You must provide a phone number where you can be contacted or a message can be left.*** Three attempts will be made to contact you to schedule any further appointments needed to determine your eligibility for services.
3) Please make sure to complete all of the application.

Authorization to Release Records:

1) On the first line of this form please provide the name of the person who is authorizing to release the records for the applicant i.e., parent, court-appointed guardian, or the individual.
2) The second line of the form is for the name of the agency or school district that will release information to the Fayette County Board of DD to assist with determining eligibility. ***Be sure to include an address and phone number for the agency or school district.***
3) The fourth and fifth lines are for the ***applicant's name and date of birth.***
4) Please sign and date the second page of the form. *If you are signing as a representative, parent, or court-appointed guardian for the applicant please sign and date as 'signature of personal representative'.*
5) Please make sure to complete the application as outlined above in order to complete the eligibility process as timely as possible.

FAYETTE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

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1330 Robinson Rd.
Washington C.H., Oh 43160
740-335-7453 Fax: 740-335-2185

APPLICATION FOR ELIGIBILITY

Applicant Name: _____ _____
First Middle Last Date of Birth

Address: _____
Street City State Zip Code

Phone: _____ Phone: _____

Custodial Parent(s)/Guardian Name: _____ Court-Appointed Guardian ____ Yes ____ No

Custodial Parent(s)/Guardian Address (if different from above)

_____
Street City State Zip Code

Phone: _____ Phone: _____

School District: [ ] Miami Trace [ ] Washington City Schools Enrolled: ____Yes ____No ___Vocational

Does applicant have 1 or more disabilities or delays? ____Yes ____No ____Unknown
Please explain: _____

_____

Has applicant received services from another agency/organization/school? _____ No _____ Yes

If yes, from whom? _____

_____ _____ _____
Applicant Signature Date Parent/Guardian Signature Date

For County Use Only

Date Application Received

Recommendations:
[ ] Approved
[ ] Denied
[ ] Referred to other agencies/Provided resources
[ ] Notified of administrative resolution of complaint process

_____ _____
Superintendent or Designee Signature Date

Fayette County Board of DD Authorization to Use or Disclose Information

NAME		DATE OF BIRTH	
ADDRESS			

I hereby authorize the Fayette County Board of Developmental Disabilities (FCBDD) to use or disclose my Protected Health Information (PHI) as described below. I am aware that my confidential personal information may be sent electronically.

The following specific person/entity is authorized to use or disclose PHI about me. I understand that the person(s)/organization(s) listed below may not be covered by state/federal rules governing the privacy and security of data and may be permitted to further share the information that is provided to them.

Name of Person/Entity	Relationship and/or Title

I am authorizing that the specific PHI below can be used or released by FCBDD (Please X all that apply).

Day Supports		Dental Records/Treatment		School Records	
Vocational Habilitation		Mental Health Records/Treatment		Emergency Contact	
Residential		OOD/Employment		Family Demographics	
Transportation		JFS		Financial Information	
Medical Records/Treatment		Social Security		Other:	

IF OTHER, PLEASE SPECIFY IN THE BOX BELOW WHAT PHI MAY BE USED OR DISCLOSED

SPECIFY REASON/PURPOSE INFORMATION IS BEING USED OR DISCLOSED

The specific purpose of the authorized use or disclosure of PHI is for FCBDD to assess eligibility, perform service coordination, and planning activities, and ensure continues and appropriate service delivery as specified in the individual's service plan.

Acknowledgement

I understand that these records are protected by HIPAA Privacy Rule (45 CFR ~164.500-534) and Ohio laws governing confidentiality rules and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I am permitted to revoke the authorization to share my health data at any time and can do so by submitting a request in writing to the Fayette County Board of DD located at 1330 Robinson Rd, Washington Court House, OH 43160. I understand that if my information has already been shared by the time my authorization is revoked, it may be too late to cancel the permission to share my health data. I understand that the failure to sign/submit this authorization or the cancelation of this authorization will not prevent me from receiving any treatments or benefits or to pay for the services I receive. Information and records of diagnosis and/or treatment of drug or alcohol conditions are protected by Federal confidentiality rules (42 CFR part 2) and may not be further disclosed without my written consent. A copy of the authorization shall have the same force and effect as the original. Consent to release/obtain information will end one year from the date of signature unless otherwise noted.

This authorization to share my PHI is valid from **Start Date:** **End Date:**

Signature of person/representative:		Date:	
If a representative is signing, please note authority of the representative to act on behalf of the person served.			