



of Summit and Portage Counties  
 3869 Darrow Road, Suite 109  
 Stow, Ohio 44224  
 (330) 836-5863  
 Fax (330) 836-6043  
 TheArcNeo.org

Request for Family Support Services

Date:  /  /   
 Individual's Name  DOB  /  /   
 \*\*Please fill out an additional form for each individual \*\*

Guardian(s)/Household contact:

Address: Street City State Zip

Home Phone: Work Phone: Cell Phone:

E-Mail: PLEASE INCLUDE E-MAIL ADDRESS FOR RAPID COMMUNICATION

**TYPE OF SERVICES REQUESTED:**

In Home Respite:  \*Home Modification   
 Out of Home Respite  specify Summer Camp  specify  
 \*Adaptive Equipment  Sum Fun (CYO)   
 Other  Pending approval

**\*Please submit specific item list/invoice/estimate and catalogue pages or other printed information for consideration by Summit DD for Adaptive Equip or Home Mods.**

**PLEASE COMPLETE THE INCLUDED SEMI-ANNUAL PREAUTHORIZATION FORM. ONLY SERVICES WITH AN APPROVED PREAUTHORIZATION FORM WILL BE PAID.**

***THE PERSON APPLYING IS RECEIVING THE FOLLOWING SERVICES:***

Medicaid CORE/Core Plus  County Board Residential Supports   
 Transition/Home Care Waiver  Level One/ I/O Waiver

***PROVIDER INFORMATION***

I would like to select a certified respite provider from the attached list YES  NO

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I have designated a family chosen provider. Their information is listed as follows:



Family Chosen Provider:

Provider Name:

Address:

Street

City

State

Zip

Home Phone:

Work/Cell Phone:

**Families selecting their own provider must complete the Waiver for Provider Training.**

***Waiver for Provider Training for Family Chosen Provider listed above.***

*The Ohio Administrative Code states that families can select their own providers. Family selected providers can be relatives or friends and do not require training*

*I understand by signing this waiver, the family assumes that all health and safety needs of the individual will be met by the Family Selected Provider. I also understand that I assume all responsibility for liabilities for injuries resulting from a violation in health and safety while my family member is in the care of the Family Selected Provider.*

Guardian/Household contact

Please Print

Individual's Name:

Please Print

Guardian/Household contact Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have received the 2010 Family Support services Plan, Bill of Rights, MUI/UI information and the

(Guardian/Contact please initial) **resolution compliant process forms and given copies to the provider listed above.**

***Family Income Information***

The Ohio Administrative Code requires that families enrolling in the Family Support Services Program provide the total taxable income for their household for the previous year.

I hereby certify that the total taxable income in 2009 for my household was \$

**\*\* Please send a copy of the most current year 1040 document for all wage earners in the household.**

By checking this box, I hereby certify no taxable income was earned in my household in 2009

Guardian/Household Contact Signature: \_\_\_\_\_

**Family Support Services are funded locally through Summit DD**

**Please Submit Request For Services to:**

The Arc of Summit and Portage Counties

Attn: Verna Whitmire - FSS Program Director

3869 Darrow Road - Suite 109, Stow, Ohio 44224

Phone 330-836-5863 ☎ Fax: 330-836-6043 ☎ e-mail Verna.Whitmire@thearcneo.org

**For Use By The Arc Only**

Date Received: \_\_\_\_\_ Date of Response to Request: \_\_\_\_\_

FSS Program Director or Executive Director Signature: \_\_\_\_\_



**GREEN**