WILLIAMS COUNTY BOARD OF DD
FAMILY SUPPORT SERVICES

FUNDING REQUEST

Name of Applicant: ______________________________

Name of Person with Disability: ______________________________

Email address to send notification of approval/denial: ______________________________

Please mark the type of funding being requested (***must be submitted and approved prior to purchase or service being rendered):***

[ ] Adaptive equipment   [ ] Direct Service   [ ] Diet

[ ] Education or training   [ ] Home/Vehicle modification   [ ] Respite   [ ] Other

Describe the type of service or indicate how this will assist you with the care of the above named individual:

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Attach any documentation which you may have (doctor's report, prescriptions, cost estimates, etc)

[ ] **Counseling** - Explain who you wish to see and why. Attach any helpful documentation for request.

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[ ] **Education or training** - Attach registration requests, copy of course description, cost estimates, etc.

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[ ] **Respite**

[ ] Beginning date and time for respite: Date: ______________ Time: ________ [ ] am [ ] pm

[ ] End date and time for respite: Date: ______________ Time: ________ [ ] am [ ] pm

[ ] I have requested ______________________________ to provide respite services.

*Please have request to Williams County Board of DD **one** week prior to requested date of service. Unless it is an emergency, if the request Is not in prior to the requested date of service **it will not be approved, and you will be responsible for the service.***

List other sources of funding or other organizations that have been contacted to share in the funding.
(Insurance, Medicaid, BVR, etc.)

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Signature of Applicant: ______________________________ Date: ______________________________

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Approval Number: ______________________________ Date approved: ______________

Reason for Denial: ______________________________

FSS Coordinator Signature: ______________________________
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