WILLIAMS COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
11246 STATE ROUTE 15 MONTPELIER, OH 43543 PHONE: 419.485-8331 FAX: 419.485-5495

Referral/Consent Form

Applicant Information: Date:_____

Name:_____
Address: _____
Telephone: (___)_____
Soc. Sec. #: _____ Date of Birth: _____
Medicaid Number:_____ Medicare Number:_____
Other Insurance- Name/Number:_____
Race: _____ Hispanic or Non?:_____
Living Arrangements of Individual:_____
****

Contact person:_____Relationship:_____
Telephone: (____)_____ Email:_____
Diagnosis/Type of Disability (Disabilities) AND Date of Diagnosis (before age 22):

Has the applicant ever received any County Board of DD services ____yes ____no ____unknown
If yes, list County and date of enrollment: _____
School attended: _____ Grade:_____ IEP?_____

Nature of Need (be specific): _____
_____
_____
_____

Referred By (Name/Title):_____
Agency & Address:_____
Telephone: (____)_____ Email:_____

Please include documentation of developmental disability prior to age 22 with referral form. Documentation may include medical records showing diagnosis, school records (ETR or MFE), psychological evaluations, etc. Diagnosis must be verified (signed) by a doctor. This applies to individuals age 6 and up. For individuals age 3-5, please submit a copy of the IEP with this form.

SEE REVERSE SIDE/PAGE TWO FOR INDIVIDUAL/GUARDIAN CONSENT

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By signing below you are confirming that you approve of yourself or the applicant named above receiving services and wish for the WCBDD to contact you and provide assistance. Please know that the WCBDD may communicate with the referring person or agency to exchange information or give updates regarding the referral.
******If you do not wish that contact is made to the referring individual or agency, please initial here:*** _____

_____
Printed Name of Individual, Parent or Guardian

_____ _____
Signature of Individual, Parent or Guardian Date

To be completed by WCBDD:

Date Referral Received: _____
Date Applicant Contacted:_____
Date Referral Closed:_____
Date Passed on for Eligibility Determination (if applicable): _____
Date C/OEDI Administered: _____
Results: _____
Signature of C/OEDI Administrator:_____

*Send this form to individual's file when completed.
**This form may only be revised by the SSA Supervisor.