

Community Services Division

Behavior Support Services

Family Support Services

Investigative Services

Medicaid Programs

Public Education

Service Coordination

Special Olympics/Recreation

245 N. Valley Road
Xenia, OH 45385

(937) 562-6500
(937) 562-6539 Fax
www.greenedd.org

The information you need to submit when requesting adaptive equipment through the Family Support Services Program is as follows:

1. A prescription or statement from a Physician/therapist/Professional recommending the equipment or request must be attached.
2. Two proposals for the equipment should be attached indicating the approximate cost of the item from each company.
3. The Family Support Services Program is considered a last dollar resource program. This means when requesting equipment, it will be necessary for you to contact other agencies for funding sources such as the following: your insurance company, Bureau of Medically Handicapped Children, or Medicaid. If the item requested is not covered under these sources, you must submit a denial letter with your request. FSSP will assist with co-payments.

Upon submission of the completed request, it will be reviewed and you will be notified as to the determination of funding. After notification of approval from our office, arrangements can be made for ordering the item.

If you have any questions regarding the criteria for your request, please feel free to contact me at (937) 562-6500 ext. 6510.

Sincerely,

Janel Lee

Family Support Services Coordinator

**GREENE COUNTY BOARD OF DD**

**FAMILY SUPPORT SERVICES PROGRAM**

**FSSP REQUEST FORM RETURN FORM TO:**

 **Greene County Board of DD**

 **Attn: Janel Lee**

 **245 North Valley Road**

**Xenia, Ohio 45385**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Street) (City) (State) (Zip Code)**

**Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: Male \_\_\_\_ Female\_\_\_\_**

**Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Street) (City) (State) (Zip Code)**

**Nature of Request: \_\_\_\_ Adaptive Equipment \_\_\_\_ Special Diet**

 **\_\_\_\_ Home Modifications \_\_\_\_ Education/Counseling/Training**

 **\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Explanation of Need: (Include estimation of materials and labor if applicable.)**

**Requests for adaptive equipment and special diet must be accompanied by a physician’s prescription.**

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**FSSP is a last dollar resource. You must first make your request to other primary sources of funding such as those listed below. When one of these sources does not provide funding, you must submit written verification of the denial of funding.**

**\_\_\_\_\_ Private Insurance \_\_\_\_\_ Easter Seals \_\_\_\_\_ Other (Please Specify)**

**\_\_\_\_\_ Medicaid \_\_\_\_\_ United Cerebral Palsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_ Medicare \_\_\_\_\_ Bureau of Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Medically Handicapped \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACTION TAKEN: Approved \_\_\_\_\_ Disapproved: \_\_\_\_\_**