Service & Support
Athens County Board of DD

Application for Services

Name ________________________________ DOB ____________ Gender :____________

Address____

Phone Number_____________________ Alternate Phone number ____________________

SSN ____________________ Medicaid Number_______________________________

Race/Ethnicity__________________________ Email_________________________

School__________________________ Primary Care Doctor_________________________

Services Requested

☐ Case management ☐ Family Support Services

Parent or Guardian Name & Phone number ____

Parent or Guardian Address ____

Preferred communication: ☐ Email ☐ Phone ☐ Text ☐ Mail

Developmental Disability Diagnosis____

Medical or Psychiatric Diagnosis____

Accommodations or assistive devices ____

How did you hear about us? ____

Applicant's signature____

Parent/ Guardian Signature____