VERIFICATION OF NEED Form

2025 FSS Program

FULTON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Parent/guardian shall complete Section 1. After that is completed, the professional whom is recommending the item or service shall complete Section 2. Upon both sections being complete, return the form to the Board.

SECTION 1—Family Completes this Section

Individual Enrolled: _____ **DOB:** _____
First & Last Name

Parent/Guardian Name: _____

Relationship to Person Enrolled: ☐ Parent ☐ Legal Guardian

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

Email Address: _____

List items or services being requested:

_____

_____

_____

_____

_____

_____

How do you think this would assist your child: _____

_____

_____

_____

_____

_____

_____

_____

_____

Who is recommending this item(s) or service(s)? _____

Please indicate by either 'X' or 'N/A' the other funding resources applied for or denied?

___ Family Medical Insurance ___ Medicaid

___ BCMH (Bureau for Children with Medical Handicaps) ___ Other: _____

It is crucial to investigate and evaluate all potential funding options before resorting to FSS funding. Assistance from the FSS program is regarded as a final option for covering eligible expenses.

I certify that all of the information provided is accurate and true.

_____ _____

Parent/Guardian Date

FCBDD, FSS PROGRAM ◆ 1210 N. OTTOKEE STREET ◆ WAUSEON, OH 43567
419-337-4575 ◆ FAX419-335-3082

FULTON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

SECTION 2—Completed by the Professional Recommending the Items/Services

Professional's Name: ____________________

Title: ____________________ **Phone:** ____________________

Address: ____________________

Email: ____________________

Explain the necessity for the item(s) or service(s), detailing how they connect to the individual's disability and address their current needs.

____

____
Signature of Professional

____
Date of Recommendation

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