

**Date received in office: \_\_\_\_\_\_\_\_\_\_\_**

**MUSKINGUM COUNTY BOARD OF DEVELOPMENTAL DISABILITIES**

**Family Assistance Program Application**

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

Name of Individual: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent or Guardians’ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a County Board employee or member of the Muskingum County Board of DD? \_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_ No

I also hereby certify that I understand that eligibility in the Family Assistance Program does not necessarily qualify me or my dependent to receive any other services from the Muskingum County Board of Developmental Disabilities.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent or Guardian Signature Date

**Please return this form with any other requested information to the Service & Support Administrator (SSA) at the Community Services Office.**

**Or by mail: Family Assistance Program (FAP), 1401 Bussemer Lane, Zanesville, Ohio 43701**

**Or by email: sarah.morgan@muskingumdd.org**

**Or by fax: 740-455-4183**

**For office use only:**

Has the person been determined eligible for services by the Muskingum County Board of DD? \_\_\_\_\_\_Yes \_\_\_\_\_\_ No Does the person have an SSA? \_\_\_\_\_\_Yes \_\_\_\_\_No List the SSA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has the plan been updated to reflect the need for FAP? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

Date all required documents were received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by Director of Community Services or Designee / Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_