**Referral for Eligibility**

Thank you for your referral to DCBDD. You may submit your completed packet\* by email to intake.eligibility@dcbdd.org, or by mail/in person at the address listed below. Please allow up to 45 days for the referral to be completed. Find out more about eligibility and county board services at [www.dcbdd.org](http://www.dcbdd.org).

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  |  |  |
| **Individual’s Information** |
| Name |  | Date of Birth |  |
| Address |  |
|  |
| Phone |  | Email |  |
| Diagnoses |  |
| **Other Contact Information** (Parent, guardian, etc.) |
| Name |  | Agency |  |
| Phone |  | Email |  |

**Please submit the following with this referral form:**

|  |
| --- |
|[ ]  **\***For ages 3-5: Evaluation Team Report, orAnother report (medical, psychological, therapy) demonstrating developmental delays. |
|[ ]  **\***For ages 6+: Diagnostic report indicating a qualifying developmental disability  |
|[ ]  Birth Certificate |
|[ ]  Social Security Card |
|[ ]  Medicaid Card (if applicable) |
|[ ]  Guardianship or Adoption Orders (if applicable) |
|[ ]  Individualized Education Plan (if applicable) |

***\*The referral cannot be processed without this information.*** *Reports should be from the original source.*

**Please help us learn about our applicants!**

|  |  |
| --- | --- |
| How did you hear about DCBDD? |  |
| How long have you lived in the county? |  |
| Why did you choose to live in Delaware County? |  |
| Were you previously connected with a county board? |  |
| What services are you interested in receiving? |  |

**For Intake & Eligibility Team Use Only:**

|  |
| --- |
| **Referral Type:** [ ]  New Referral [ ]  Reactivation [ ]  County Transfer |
| **Service Recommendation:** [ ]  Self-Directed Services [ ]  Person-Centered Planning Services |
| **Notes:** |