**New Referral for County Board Services**

Thank you for your referral to DCBDD. You may submit your completed referral packet by email to [intake.eligibility@dcbdd.org](mailto: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. Learn more at [www.dcbdd.org](http://www.dcbdd.org).

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

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| --- | --- |
| **Required Documents:** *Please submit the following documents with this referral form.*  ***\* The referral cannot be processed without this information.*** | |
|  | **\***For ages 3-5: Evidence of a developmental delay:   * Most recent Evaluation Team Report from the school district **OR** * An evaluation from within the past 90 days that includes standardized scores **OR** * A diagnostic report |
|  | **\***For ages 6+: Diagnostic report indicating a qualifying developmental disability |
|  | **\***Delaware County Resident Verification (utility bill, financial statement, lease/home purchase contract) |
|  | Birth Certificate |
|  | Social Security Card |
|  | Individualized Education Plan (if applicable) |
|  | Evaluation Team Report (ETR) (if applicable) |
|  | Medicaid Card (if applicable) |
|  | Guardianship or Adoption Orders (if applicable) |

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| **Background Information** *Please help us learn about our applicants!* | | | | | |
| How did you hear about DCBDD? | | |  | | |
| How long have you lived in Delaware County? | | |  | | |
| Why did you choose to live in Delaware County? (Please select one.) | | | | | |
| DD Services | Employment | School District | | Housing | Other |
| Were you previously connected with a county board? | | |  | | |
| What are your current needs? | | |  | | |

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| **For Intake & Eligibility Team Use Only:** | | | |
| **Referral Type:**  New Referral  Reactivation  County Transfer | | | |
| **Service Recommendation:**  Self-Directed Services  Person-Centered Planning Services Ineligible | | | |
| **Notes:** | | | |
| I&E CONTACTS | Type | Date | Response |
| Contact 1 |  |  |  |
| Contact 2 |  |  |  |
| Contact 3 | Letter |  |  |