

7675 St Rt 45 Lisbon, OH 44432

330-424-0404/330-424-1184 Fax

k.beil@ccbdd.net

Referral for Eligibility

Welcome to the Columbiana County Board of Developmental Disabilities. Please complete this packet to help us better determine the services that are appropriate for your needs and begin gathering needed information. You can submit the completed documents to [k.beil@ccbdd.net](mailto:k.beil@ccbdd.net), via mail in the prepaid envelope enclosed, or drop off at our Service and Support Administration offices at the address above.

Please submit:

1. The completed **referral form** from the attached Intake packet
2. ***Submit documents or sign release(s)*** to obtain ***verification documents*** regarding **diagnoses**, **severity** of diagnoses and **need for individualized services** prior to age 22 and current needs (physicians, psychologist, schools, hospitals…)

**Copies of all the documents listed below:**

|  |  |
| --- | --- |
| **Birth certificate** | **Medicaid card** |
| **Social Security card** | **Medicare Card** |
| **Photo ID or recent Photo** | **Guardianship papers or Adoption papers** |

***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 CCBDD?*** |  |
| ***How long have you lived in our County?*** |  |
| ***If you are new to the County, why did you decide to move here?*** |  |
| ***What types of services are you interested in receiving?*** |  |
| *You may submit any other information that you wish to support your case for eligibility for services with our agency including the names and contact information of persons who know the individual well that could give input regarding their needs and abilities.* | |

Once the requested documents are received and reviewed, you will be notified concerning testing for eligibility for services or transfer into our county. If you have any questions please feel free to call Monday through Friday (8:00 AM – 4:00 PM).

Kari A. Beil, Intake Manager



COLUMBIANA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Date this form completed: \_\_\_\_\_\_­­­­\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 own guardian 🞏 has a guardian

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Medicaid 🞏 Medicare Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Caregiver 🞏 Court appointed Guardian 🞏 POA 🞏 Custodial Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently live in Columbiana County? 🞏Yes 🞏 No Have you moved within the last year? 🞏 Yes 🞏 No

If “Yes” list previous address: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Referred by:***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency (if applicable): \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What service(s) does this individual need? Check all that apply:**

🞏 School Services 🞏 Family Service & Support 🞏 Homemaker Personal Care

🞏 Adult Services 🞏 Service & Support Administration 🞏 Residential Services

**Did you receive any DD services in any other county?**  🞏 Yes 🞏No If yes, what county? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What services did you receive?** 🞏 Early Intervention 🞏 School 🞏 Day Array 🞏 Residential 🞏 SSA

I**ndividual’s disabilities as reported by informant:** \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Did the individual’s qualifying diagnosis disability occur before age twenty-two?** 🞎 Yes 🞏No

**Is the individual’s qualifying disability likely to continue indefinitely?** 🞎 Yes 🞏No

**What agencies/physicians/psychologists/hospitals are currently or have provided services that can both verify each diagnoses and severity of the diagnoses prior to age 22 and now?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Agency/Physician/Hospital | | Address | | | Phone | Fax | |
|  | |  | | |  |  | |
|  | |  | | |  |  | |
|  | |  | | |  |  | |
| Medication Name  Date Filled | Dose | | Frequency | Prescribing Physician | | | Related Diagnosis or Condition | |
|  |  | |  |  | | |  | |
|  |  | |  |  | | |  | |
|  |  | |  |  | | |  | |
|  |  | |  |  | | |  | |

**EDUCATION:**

**Elementary School** - Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**High School** - Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Graduated: 🞏 Yes 🞏 No G.E.D.: 🞏 Yes 🞏 No

**VOCATIONAL TRAINING IN ADDITION TO ABOVE EDUCATION:** 🞏 Yes 🞏 No

**EMPLOYMENT HISTORY:**  🞏 Yes 🞏No

|  |  |  |
| --- | --- | --- |
| **Name of Employer/Address/Phone** | **Job(s) performed** | **Years of employment** |
|  |  |  |
|  |  |  |
|  |  |  |

**SUBMIT REFERRAL TO:** SSA Office- Intake Department

7675 St Rt 45

Lisbon, Ohio 44432

🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞🙞

**FOR CCBDD USE ONLY**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Superintendent’s Signature Date**

Columbiana County Board of Developmental Disabilities

**7675 St Rt 45**

**Lisbon, Ohio 44432**

**PHONE: (330) 424-0404**

**FAX: (330) 424-1184**

**CONSENT TO TEST**

I: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Guardian Name

Give my consent for an SSA representing Columbiana County Board of Developmental Disabilities to administer the

Children’s Ohio Eligibility Determination Instrument (C/OEDI) ages 6-16 or

Ohio Eligibility Determination Instrument (OEDI) ages 16 or older to:

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

Individual’s Name

To determine eligibility for Developmental Disabilities services and /or assistance where needed.

I understand that I may invite informants of my choice who could offer information or explanation that may be helpful to the tester in making a determination.

**🞎 I have read this Authorization or it has been explained to me.**

🞎 I have received a copy of the Columbiana County Board of Developmental Disabilities

**Notice of Privacy Practices**

🞎 I was offered an opportunity to register to vote.

*\*In compliance with policies and procedures of confidentiality pursuant to Rule 3301-52-02 of the Administrative Code and 34 CFR Regulation 99.3.[[1]](#footnote-1)⊛*

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

Signature of Client or Guardian Date

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

Signature of Guardian: Date

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

Witness Signature Date

**Ohio Department of Job and Family Services/Columbiana County Board of Developmental Disabilities**

**VOTER REGISTRATION**

**NOTICE OF RIGHTS AND DECLINATION**

**County Department of Job and Family Services: COLUMBIANA**

**Name:**

**Date:**

**If you are not registered to vote where you live now, would you like to apply to register to vote here today?**

🞎 YES, I want to register to vote or update my voter registration today

🞎 No, I do not want to register to vote today

🞎 I am currently registered to vote and my registration information is current and accurate

🞎 I am not eligible to vote due to court determination of incompetency, I am underage or I am not a citizen

**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

*Applying to register or declining to register will not affect the amount of assistance that you will be provided by this agency.*

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

**Name of CCBDD individual assisting you today:**

**Kari A. Beil, SSA**

**Signature:**

**(This portion to be retained by agency)**

**-----------✂ ---------------------------------------------------------------------------------------------------------**

**(This portion to be given to applicant/recipient)**

Date:

If you have not received any verification of your voter registration from the county board of elections in which you reside within 21 days from the date you registered, you may inquire about the status of your registration by contacting your county board of elections. (*7989 Dickey Drive Suite 3, Lisbon, Ohio 44432-8394*------330-424-1448)

If you think that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or political preference, you may file a complaint with the prosecuting attorney of your county or with the Secretary of State:

**County Prosecutor: Vito Abruzzino**

**Ohio Secretary of State**

**Address of County Prosecutor:**

**105 South Market Street, Lisbon, Ohio 44432-1295**

**180 East Broad Street**

**Columbus, Ohio 43125**

**Phone Number of County Prosecutor: 330-424-6677**

**(616) 466-2585**

**Toll Free: (877) 868-3874**

*CCBDD Compliance Form: National Voter Registration Act of 1993; Section 3503.10 of the Revised Code of Ohio 12/06/2011*

# Notice of Privacy Practices

Columbiana County Board of Developmental Disabilities

|  |  |  |
| --- | --- | --- |
| FOR YOUR PROTECTION | This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. It also describes our practices about Robert Bycroft School records. | |
| YOUR RECORDS ARE PRIVATE | We understand that information we collect about you or your child and records of the services and supports we provide, are personal. Keeping these records private is one of our most important responsibilities. The Board must follow many laws to protect your privacy. For the Robert Bycroft School records, we follow the federal FERPA laws. For adult services, and certain services for children, we follow the federal HIPAA laws. In addition, we follow many laws specific to Ohio Department of Developmental Disabilities Boards. For this notice, we will use the term “records” to mean the paper or electronic records we maintain about you. | |
| WHO USES AND DISCLOSES MY RECORDS? | Your records may be used and disclosed by the employees and volunteers at the Board who serve you, as well as persons or agencies who work for us and sign strict confidentiality contracts.  Our organization includes [Robert Bycroft School] [Adult Senior Center] [EDI Central] [EDI South] [Beaver Creek Candle Co.] [SSA Department] [Transportation Department] [CCBDD Administration] [Service Coordination] [ Adult Services] [Residential] [Early Intervention].  At Robert Bycroft School, for example, records may be shared with “school officials” who have a “legitimate educational interest” in your child. “Educational interest” means any matter related to your child’s instruction, developmental or behavioral support, dietary, health or safety. “School officials” include teachers, paraprofessionals, aides, bus drivers and administrators at Columbiana County Board of Developmental Disabilities.  In general, we use and disclose your information:   * For teaching, behavioral and medical support, transportation and school administration. For example, a school administer will review progress data created by teachers. * To provide the full range of services we provide: early intervention, habilitation, supported employment, and other services. For example, your service and support administrator will review your records to create an individual service plan, which may be shared with you, your guardian, and other individuals involved with providing services and supports to you. * To get payment for services provided, * For other operations to operate and manage the board: these include improving quality of care, training staff, managing costs, and conducting other business duties. For example, a quality assurance reviewer may audit your records to determine whether appropriate services were provided, and * To remind you or a guardian of an appointment for services. | |
| COULD MY RECORDS BE RELEASED WITHOUT MY PERMISSION? | There are limited situations when we are permitted or required to disclose your records, or parts of them, without your signed permission. These situations include:   * Record transfers to other schools your child enrolls in, * Reports to public health authorities to prevent or control disease or other public health activities, * To protect victims of abuse, neglect, or domestic violence, * For oversight including investigations, audits, accreditation and inspections, such as are conducted by the Ohio Department of Developmental Disabilities and federal agencies, * When a court order, subpoena or other legal process compels us to release information, * Reports to law enforcement agencies when reporting suspected crimes, when responding to an emergency, or in other situations when we are legally required to cooperate, * In connection with an emergency, or to reduce or prevent serious threat to public health and safety, * To coroners, medical examiners and funeral directors, * To victims of alleged violence or sex offenses, * For workers’ compensation programs, * For specialized government functions including national security, protecting the president, operating government benefit programs, and caring for prisoners, * In connection with “whistleblowing” by an employee of the Board.   All other uses not described above require that we obtain your signed permission. | |
| WHAT IF MY RECORDS NEED TO GO SOMEWHERE ELSE | For any purpose not described above, we will release your information only with your explicit written authorization. Federal law requires the that we notify you that any healthcare provider must obtain your explicit permission to release your information for any of the following:  1. Psychotherapy Notes will only be released with your signed authorization;  2. For marketing purposes;  3. To sell information about you.  It has never been the board’s practice to release information for marketing purposes or to sell your information. Your written authorization tells us what, where, why and to whom the information must be sent. Your signed authorization is good until the expiration date you specify. You can cancel your permission at any time by letting us know in writing. | |
| WHAT ARE MY RIGHTS REGARDING PRIVACY, ACCESS TO MY RECORDS, AND THE ACCURACY OF MY RECORDS? | You have legal rights concerning your privacy, access to your records, and the accuracy of your records. You have the following rights:   1. To see your records, or to get a copy, including an electronic copy; 2. To request a correction to your records if you believe they are incorrect; 3. To receive all communications at a confidential address or phone number; 4. To receive an “accounting of disclosures”, that is, a list of any place we sent your record without your authorization; 5. To request additional limits on how we use or disclose your information, although we are not obliged to honor these requests except that if you choose to personally pay for services delivered, we will not bill Medicaid. 6. You may receive a paper copy of this notice.   To exercise any of these rights, or if you have any questions or complaints regarding our privacy practices, call, deliver, mail or email your request to:  HIPAA Compliancy Officer  Columbiana County Board of DD  7675 State Route 45  Lisbon, OH 44432  (330) 424-7788  c.lawton@ccbdd.net  Ask any employee if you need help in putting your request in writing. | |
| OUR DUTIES | We are obligated by law to maintain the privacy of your information and to provide this notice. In the event of a breach, that is, an improper disclosure of your information, we are required to notify you. We are required by law to abide by the terms of this notice. From time to time we may make changes to our policies, and if and when we do, your records will be protected by our new, changed policies. Our current notice will always be available on our website. | |
| QUESTIONS OR COMPLAINTS? | If you have any questions or complaints about our privacy practices, please contact us:  Attn: HIPAA Compliancy Officer  Columbiana County Board of DD  7675 State Route 45  Lisbon, OH 44432  (330) 424-7788  We will never retaliate against you for filing a complaint. Further, if you are not satisfied with the results, you may also complain to the federal government: | |
|  | **For School issues**:  Family Policy Compliance Office  U.S. Department of Education  400 Maryland Avenue, SW Washington, D.C. 20202 | **For any other issues:**  Secretary of Health and Human Services  200 Independence Avenue, SW  Washington, D.C. 20201  www.hhs.gov/ocr/privacy/hipaa/complaints/index.html |

Original Notice effective 4/14/2002; Current Revision effective 7/1/2013.

# Columbiana County Board of Developmental Disabilities (CCBDD)

# Intake Authorization Form

|  |  |  |
| --- | --- | --- |
|  | Columbiana County Board of DD Intake Department  7675 St Rt 45, Lisbon, OH 44432  330-424-0404  k.beil@ccbdd.net |  |

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name of Individual Served \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Dates of Service \_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_ Social Sec. # \_\_\_\_\*\*\*-\*\*-\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize Columbiana County Board of Developmental Disabilities to:*

|  |  |
| --- | --- |
| **Release to**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **OBTAIN FROM**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| The following information:  🞏 Assessment and diagnosis (MFE)  🞏 Treatment and progress  🞏 Social History  🞏 Psychological Test results  🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | The following information:  🞏 Assessment and diagnosis (MFE) (F.E.D.)  🞏 Treatment and progress  🞏 Most current IP (ISP, IEP, ETR, IHP)  🞏 Psychological Test results  🞏 Results of recent physical examination  🞏 Other \_Include medications list with frequency, dose, purpose; LIST DIAGNOSIS |

The purpose of this disclosure is

🞏 Coordination of care

🞏 Requested by Individual Receiving Services, or guardian/parent

🗷 Other \_Eligibility Determination for DD Services\_\_\_\_\_\_\_

1. I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2. I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3. The CCBDD does not require that I sign this authorization in order to receive services.

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by someone other than the Individual being served:

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Authority to sign: 🞏 Parent or Guardian

🞏 Appointed by Individual as HIPAA Personal Representative

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:

🗷 90 days from date signed

🞏 other date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*FOR STAFF USE* (complete the following steps and indicate by a check. Name of Staff Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Copy of signed authorization given to Individual / Parent / Guardian

\_\_\_ Copy of records released given to individual / Parent / Guardian (if requested)

\_\_\_ Disclosure logged on Disclosure Log

\_\_\_ Revocation received on \_\_\_\_\_\_\_\_\_\_ and acted upon.

# Columbiana County Board of Developmental Disabilities (CCBDD)

# Intake Authorization Form

|  |  |  |
| --- | --- | --- |
|  | Columbiana County Board of DD Intake Department  7675 St Rt 45, Lisbon, OH 44432  330-424-0404  k.beil@ccbdd.net |  |

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name of Individual Served \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Dates of Service \_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_ Social Sec. # \_\_\_\_\*\*\*-\*\*-\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize Columbiana County Board of Developmental Disabilities to:*

|  |  |
| --- | --- |
| **Release to**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **OBTAIN FROM**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| The following information:  🞏 Assessment and diagnosis (MFE)  🞏 Treatment and progress  🞏 Social History  🞏 Psychological Test results  🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | The following information:  🞏 Assessment and diagnosis (MFE) (F.E.D.)  🞏 Treatment and progress  🞏 Most current IP (ISP, IEP, ETR, IHP)  🞏 Psychological Test results  🞏 Results of recent physical examination  🞏 Other \_Include medications list with frequency, dose, purpose; LIST DIAGNOSIS |

The purpose of this disclosure is

🞏 Coordination of care

🞏 Requested by Individual Receiving Services, or guardian/parent

🗷 Other \_Eligibility Determination for DD Services\_\_\_\_\_\_\_

1. I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2. I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3. The CCBDD does not require that I sign this authorization in order to receive services.

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by someone other than the Individual being served:

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Authority to sign: 🞏 Parent or Guardian

🞏 Appointed by Individual as HIPAA Personal Representative

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:

🗷 90 days from date signed

🞏 other date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*FOR STAFF USE* (complete the following steps and indicate by a check. Name of Staff Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Copy of signed authorization given to Individual / Parent / Guardian

\_\_\_ Copy of records released given to individual / Parent / Guardian (if requested)

\_\_\_ Disclosure logged on Disclosure Log

\_\_\_ Revocation received on \_\_\_\_\_\_\_\_\_\_ and acted upon.

# Columbiana County Board of Developmental Disabilities (CCBDD)

# Intake Authorization Form

|  |  |  |
| --- | --- | --- |
|  | Columbiana County Board of DD Intake Department  7675 St Rt 45, Lisbon, OH 44432  330-424-0404  k.beil@ccbdd.net |  |

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name of Individual Served \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Dates of Service \_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_ Social Sec. # \_\_\_\_\*\*\*-\*\*-\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize Columbiana County Board of Developmental Disabilities to:*

|  |  |
| --- | --- |
| **Release to**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **OBTAIN FROM**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| The following information:  🞏 Assessment and diagnosis (MFE)  🞏 Treatment and progress  🞏 Social History  🞏 Psychological Test results  🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | The following information:  🞏 Assessment and diagnosis (MFE) (F.E.D.)  🞏 Treatment and progress  🞏 Most current IP (ISP, IEP, ETR, IHP)  🞏 Psychological Test results  🞏 Results of recent physical examination  🞏 Other \_Include medications list with frequency, dose, purpose; LIST DIAGNOSIS |

The purpose of this disclosure is

🞏 Coordination of care

🞏 Requested by Individual Receiving Services, or guardian/parent

🗷 Other \_Eligibility Determination for DD Services\_\_\_\_\_\_\_

1. I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2. I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3. The CCBDD does not require that I sign this authorization in order to receive services.

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by someone other than the Individual being served:

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Authority to sign: 🞏 Parent or Guardian

🞏 Appointed by Individual as HIPAA Personal Representative

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:

🗷 90 days from date signed

🞏 other date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*FOR STAFF USE* (complete the following steps and indicate by a check. Name of Staff Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Copy of signed authorization given to Individual / Parent / Guardian

\_\_\_ Copy of records released given to individual / Parent / Guardian (if requested)

\_\_\_ Disclosure logged on Disclosure Log

\_\_\_ Revocation received on \_\_\_\_\_\_\_\_\_\_ and acted upon.

# Columbiana County Board of Developmental Disabilities (CCBDD)

# Intake Authorization Form

|  |  |  |
| --- | --- | --- |
|  | Columbiana County Board of DD Intake Department  7675 St Rt 45, Lisbon, OH 44432  330-424-0404  k.beil@ccbdd.net |  |

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name of Individual Served \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Dates of Service \_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_ Social Sec. # \_\_\_\_\*\*\*-\*\*-\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize Columbiana County Board of Developmental Disabilities to:*

|  |  |
| --- | --- |
| **Release to**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **OBTAIN FROM**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ |
|  |  |
| The following information:  🞏 Assessment and diagnosis (MFE)  🞏 Treatment and progress  🞏 Social History  🞏 Psychological Test results  🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | The following information:  🞏 Assessment and diagnosis (MFE) (F.E.D.)  🞏 Treatment and progress  🞏 Most current IP (ISP, IEP, ETR, IHP)  🞏 Psychological Test results  🞏 Results of recent physical examination  🞏 Other \_Include medications list with frequency, dose, purpose; LIST DIAGNOSIS |

The purpose of this disclosure is

🞏 Coordination of care

🞏 Requested by Individual Receiving Services, or guardian/parent

🗷 Other \_Eligibility Determination for DD Services\_\_\_\_\_\_\_

1. I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2. I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3. The CCBDD does not require that I sign this authorization in order to receive services.

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by someone other than the Individual being served:

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Authority to sign: 🞏 Parent or Guardian

🞏 Appointed by Individual as HIPAA Personal Representative

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:

🗷 90 days from date signed

🞏 other date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*FOR STAFF USE* (complete the following steps and indicate by a check. Name of Staff Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Copy of signed authorization given to Individual / Parent / Guardian

\_\_\_ Copy of records released given to individual / Parent / Guardian (if requested)

\_\_\_ Disclosure logged on Disclosure Log

\_\_\_ Revocation received on \_\_\_\_\_\_\_\_\_\_ and acted upon.

# Columbiana County Board of Developmental Disabilities (CCBDD)

# Intake Authorization Form

|  |  |  |
| --- | --- | --- |
|  | Columbiana County Board of DD Intake Department  7675 St Rt 45, Lisbon, OH 44432  330-424-0404  k.beil@ccbdd.net |  |

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name of Individual Served \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Dates of Service \_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_ Social Sec. # \_\_\_\_\*\*\*-\*\*-\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize Columbiana County Board of Developmental Disabilities to:*

|  |  |
| --- | --- |
| **Release to**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **OBTAIN FROM**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ |
|  |  |
| The following information:  🞏 Assessment and diagnosis (MFE)  🞏 Treatment and progress  🞏 Social History  🞏 Psychological Test results  🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | The following information:  🞏 Assessment and diagnosis (MFE) (F.E.D.)  🞏 Treatment and progress  🞏 Most current IP (ISP, IEP, ETR, IHP)  🞏 Psychological Test results  🞏 Results of recent physical examination  🞏 Other \_Include medications list with frequency, dose, purpose; LIST DIAGNOSIS |

The purpose of this disclosure is

🞏 Coordination of care

🞏 Requested by Individual Receiving Services, or guardian/parent

🗷 Other \_Eligibility Determination for DD Services\_\_\_\_\_\_\_

1. I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2. I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3. The CCBDD does not require that I sign this authorization in order to receive services.

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by someone other than the Individual being served:

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Authority to sign: 🞏 Parent or Guardian

🞏 Appointed by Individual as HIPAA Personal Representative

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:

🗷 90 days from date signed

🞏 other date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*FOR STAFF USE* (complete the following steps and indicate by a check. Name of Staff Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_ Copy of signed authorization given to Individual / Parent / Guardian

\_\_\_ Copy of records released given to individual / Parent / Guardian (if requested)

\_\_\_ Disclosure logged on Disclosure Log

\_\_\_ Revocation received on \_\_\_\_\_\_\_\_\_\_ and acted upon.

1. ⊛ 7675 State Route 45, Lisbon, Ohio 44432 Phone: 330-424-0404 FAX: 330-424-1184 [↑](#footnote-ref-1)