



# Delaware County Board of Developmental Disabilities

*To inspire, empower, and support people to achieve their full potential.*

## Referral for Eligibility Determination

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

Name: \_\_\_\_\_ DOB/Age: \_\_\_\_\_

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

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Current Diagnosis: \_\_\_\_\_

How did you hear about DCBDD? \_\_\_\_\_

How long have you lived in Delaware County? \_\_\_\_\_

If new to the county, what made you decide to live here? \_\_\_\_\_

What type of services are you needing help with? \_\_\_\_\_

Please submit the following documents:

Birth Certificate

Social Security Card

Medicaid Card (if applicable)

Guardianship or Adoption Papers (if applicable)

Please provide documentation to support the diagnosis:

ETR (Evaluation Team Report) and IEP (Individual Education Plan)/504 Plan

Medical or Psychological Evaluation

Other Diagnostic Information

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### Intake Department Use Only:

New to system

Inter-county transfer

Received county board services in the past

Referral to

SSA

SDP