



Southwest Ohio Council of Governments

Family Support Services Program

1520 Madison Road, Cincinnati, Ohio 45206

phone- (513) 559-6800, fax- (513) 559-6600, TDD (513) 475-0025

VERIFICATION OF NEED FORM (FSSP)

Name of person enrolled: _____ Date: _____

Address: _____ Phone: _____

Contact person: _____ Email address: _____

Type of service/item requested: _____

(We will also need a printed price quote from the provider for equipment purchases or home modifications that list the name and address of the provider, the item or modification needed, and the total cost.)

Please indicate by either an "X" or "N/A" the alternate funding resource applied for or denied to the family.

- _____ Family's Insurance
- _____ Medicaid/Medicare 1-800-324-8680/1-800-772-1213
- _____ BCMH (Bureau for Children w/Medical Handicaps) 1-800-755-4769
- _____ BVR (Bureau of Vocational Rehabilitation) Cincinnati area 852-3260/1-800-228-5405
- _____ Board of DD Services (Hamilton 794-3300, Clermont 732-7000, Butler 867-5600)

Individual/Family signature: _____

This section to be completed by the professional recommending the service/item requested. The professional completing this section can be the doctor, therapist, teacher, case manager, or County Board of DD Services professional, working with the person enrolled. If you enclose a separate letter of need from the professional, we do not need this section completed.

Professional's name: _____ Title: _____

Address: _____ Phone: _____

Signature: _____

Brief statement of why service/item is needed and how it relates to the persons disability: _____

Send completed form to: SWOCOG - Family Support Services Program
 1520 Madison Road
 Cincinnati, Ohio, 45206
 Fax 513-559-6600 or Email: sandy.schutte@hamiltondds.org