Hocking County Board of Developmental Disabilities

Application for Enrollment

Applicants Information

Name: _____ **DOB:** _____

Address: _____

_____

County: _____ **Phone:** _____

Email: _____

Gender: Male / Female **Social Security Number:** _____

Medicaid # _____ **Medicare #** _____

Other Insurance Name: _____ **Please provide copy of insurance card.**

Does the applicant have any of the following?

Custodial Parent (if under 18) Yes / No If yes, fill out contact section below.

Legal Guardian/Power of Attorney Yes / No If yes, fill out contact section below.

Social Security Payee/Other Payee Yes / No If yes, fill out contact section below.

Contact Information

Name: _____

Address: _____

_____

Phone: _____

Email: _____

Questionairre/History

Received County Board services before (if yes, when/where)? _____

Family member receiving County Board services (if yes, who)? _____

Diagnosis/Condition: _____

Physician/Psychiatrist: _____

Signature of Individual/Parent/Guardian _____ **Date:** _____

Please return this form to HCBDD at 1369 E Front Street Logan, OH 43138 or fax (740) 385-9265.
If you have questions or need assistance, please call (740) 385-6805 ext. 227