Rental Assistance Application for One-Time Funds July 1, 2018 - June 30, 2019

Ohio Department of Developmental Disabilities

If someone is filling out this application on behalf of the applicant or if the applicant would like to authorize someone to serve as the contact person for this application, complete the authorization at the end of this application.

Applicant Information

Date	Name	Name of facility, if applicable

Address	Phone number	☐ Developmental center ☐ Private ICF ☐ County operated ICF ☐ Other

Are you currently or in the process of being enrolled on a Home and Community Based Services (HCBS) waiver? ☐ Yes ☐ No	If yes, waiver type ☐ IO ☐ Level One ☐ SELF
	Do you have a new home or apartment selected? If yes provide the address. ☐ Yes ☐ No

Address of selected home or apartment	City	County	Zip

Funding Requests

Item requested	Amount of request
	$
	$
	$
	$
	$
	$

Signatures

I certify that, to the best of my knowledge, the information I have provided is accurate.

Applicant Signature	Date

I authorize _____ to complete this application on my behalf and to provide any information necessary in order to provide a complete application and to represent me as needed in order to assist me in obtaining assistance.

Name of Authorized Representative	Signature of Applicant

Address of Authorized Representative	Authorized Rep Phone Number

Name of County Board SSA	SSA Phone Number	SSA Email

Email application to: doddrap@dodd.ohio.gov

DODD Use Only

Date application received	Time	Reviewed by	Date

☐ Approved ☐ Denied	If denied, basis for denial
	Signature of DODD Representative