Family Income Verification

Eligible individual's name(s): _____

Birth date of individual(s): _____

# of persons eligible for DD services in home NOT receiving financial support from ECBDD: _____

# of individuals living in home:_____**Service Coordinator/SSA:**_____

Parent/Guardian's name: _____

Address:_____

Telephone number: _____**Email Address:**_____

Please provide the following documents:

____ Federal Tax return cover page

_____Previous or current federal tax return page that shows "taxable income"
(Usually line 43 or 27.)

OR

____ Current Medicaid Card of Head of Household

I certify that the document attached is accurate and includes the income of all individuals in the household who provide for the eligible individual. **Mis-use of funds may result in termination of FDR for 1 year.**

_____ _____

Signature Date

Complete above, include requested copy and return to:

Ability Works, Inc.
Attention: Kristy Ferback
1 Superior St.
Sandusky, Ohio 44870
Email: kferback@ability-works.com
Phone Number: (419)626-1048 x 3111

Plan name and number:_____Verified by:_____Date:_____

Eligibility Verified by:_____ Date: _____

Approval Dates: _____

3/8/2017