



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: Wendy Dempsey
1 Superior St.
Sandusky, Ohio 44870
Email: wdempsey@ability-works.com
Phone Number: (419)626-1048 x 3104**

Plan name and number: _____ Verified by: _____ Date: _____

Eligibility Verified by: _____ Date: _____

Approval Dates: _____