

FAMILY SUPPORT SERVICES PROGRAM
801-A WEST EIGHTH STREET, #400
CINCINNATI, OHIO 45203
(513) 821-2128 EXT. 109
TOLL FREE 877-423-6900 EXT. 109
FAX 821-2141

Please print and mail to The Arc Hamilton County

(Please Print)

Name of Child/Adult with Disability _____

Date of Birth _____ Male _____ Female _____

Parent's/Guardian's Name(s) _____

Relationship to Client _____

Address _____

City _____ State _____ County _____

Zipcode _____ Home Phone _____ Work Phone _____



CERTIFICATION OF DEPENDENCY & INCOME

I hereby certify that _____ lives in our Home and is dependent upon our family for his/her support & care. This form asks for the HOUSEHOLD taxable income- NOT THE INCOME OF THE INDIVIDUAL ENROLLED IN THE PROGRAM. The 200__ Federal Taxable Income, plus child support, if any, from Federal Tax Return (1040 EZ-line 6 or 1040A-line 27 or 1040-line 43) for our household was \$ _____

(Please Note) If your household is not required to file Federal Income Tax, your taxable income should be stated as zero (0).

Signature

Date

Completing all items will help determine eligibility for reimbursement for the program. After eligibility is established we will require a brief annual update of taxable income information. Eligibility would only be affected if the person with the disability no longer lives at home, or if at periodic reviews by MR/DD at the ages of 3, 6, and 16, the individual no longer meets all the criteria of the Developmental Disabilities definition.