

LUCAS COUNTY FAMILY RESOURCE SERVICES PROGRAM
 PROFESSIONAL RECOMMENDATION REQUEST

Date _____

Client Name _____ Parent/Guardian Signature _____

Professional Recommendation

Ship to _____

Firm / Agency _____

Client Name _____

Professional Name & Title _____

Parent Name _____

Address _____

Address _____ Apt. _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Phone _____ Ext _____

Phone _____

ORDER REQUESTED INFORMATION:

Company	Phone #	Item #	Description (color, size)	PRICE

Family Support Services
Contact and Submission Information
 Phone: 419-381-6139
 Lucas County Board of Developmental Disabilities
 1932 Birchwood, Toledo OH 43614
 VLambert@lucasdd.org
 Fax: 419-381-7313

OFFICE USE ONLY	
Funds Available \$ _____	Sub-Total _____
Family Co-Pay % _____	Shipping _____
Total _____	
CT _____ SD _____ AE _____ HM _____ DE _____ OT _____	
Contract # _____	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Date _____	