

Ohio Department of Developmental Disabilities
Children's Form for Eligibility Determination (CFED)

Applicant Information

<u>Name</u>	<u>Age</u>	<u>DOB</u>	<u>SS#</u>
<u>Home Address (city/state/zip)</u>			<u>Home Phone (include area code)</u>
<u>Date of Application</u>	Initial Determination: _____		Redetermination: _____

YES NO 1. Does the individual reside in the county where application for services has been made? If **no**, **STOP!** The person is not eligible in this county.

2. List all of the person's disabilities and the source of diagnosis (documentation need not be current).

<u>Disability</u>	<u>Source (e.g., Psych Report, Dr. Gibb, 5/31/95)</u>

YES NO 3. Does the person have qualifying physical or mental impairments other than a sole diagnosis of mental illness? If **no**, **STOP!** The person is not eligible.

YES NO 4. Is the person's disability likely to continue indefinitely? If **no**, **STOP!** The person is not eligible.

5. Completion of the OEDI showed substantial functional limitations in the following areas: (x all applicable):

- MOBILITY SELF CARE SELF DIRECTION CAPACITY FOR INDEPENDENT LIVING
 LEARNING RECEPTIVE AND EXPRESSIVE LANGUAGE

YES NO 6. Does the person have at least **THREE** areas of substantial functional limitation (SFL)? If **no**, **STOP!** The person is not eligible. Notify individual of eligibility decision and appeal procedure in writing.

*If **yes** to items 1, 3, 4, and 6, the person meets the eligibility requirements for the County Board of DD.*

- Individual meets the above requirements and is eligible for County Board of DD services.
 Individual **does not** meet above requirements and is **not** eligible for County Board of DD services.

Signature of Authorized County Board of DD Designee Title County Date