Provider Request Form

Instructions to Individual, Family Member or Guardian:

1. Please complete the information below to provide a brief profile of the person needing support and submit to: Joni Sparks at joni.sparks@fcbdd.org or 2879 Johnstown Road, Columbus, Ohio 43219.

2. This information will be sent to Providers, who will be asked to respond within 7 days if they would like to be considered to provide services.

3. On a separate email or piece of paper, please provide your name, email address and phone number for communication with ‘The Connector’ staff.

Profile of Person

Age: __________
Gender: ________
Zip Code where person lives: ____________
When are services needed (days of week and times)? _____________________________
__________________________________________________________
__________________________________________________________

What type of service is requested? (circle one):

<table>
<thead>
<tr>
<th>Level 1</th>
<th>SELF</th>
<th>IO</th>
<th>ICF/IDD</th>
</tr>
</thead>
</table>

Do you want an Independent Provider (IP) or an Agency Provider (AP) or either? (circle one)

<table>
<thead>
<tr>
<th>IP</th>
<th>AP</th>
<th>Either</th>
</tr>
</thead>
</table>

Does this person need assistance with (circle one):

- Medication: Yes No
- Toileting: Yes No
- Behavioral Support: Yes No
- Eating: Yes No
- Dressing: Yes No
- Walking: Yes No
- Wheelchair Transfers: Yes No

*On just one separate page, feel free to list any other special needs or details about this person that will be helpful for Providers to determine if they are a good match to provide services. Please do not include name of person or other personally identifiable information, as this information will be shared with many Providers.*

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