



County Board Funded
Provider Development Grant
Request Form Providers

Name of Event _____

Date of Event _____

***You may submit more than one request per year however,
priority will be given to those who have not yet received personal
development grant funds within the current calendar year.***

Grants are intended for the use of individuals, families and providers to assist the individual and/or his/her family to participate in events and activities that foster integration and community Inclusion. A certified independent provider may also request grant dollars for specific training relating to an individual served within Auglaize County.

This reimbursement request form must be received 30 days prior to the event. Reimbursement is not guaranteed. Email completed reimbursement request along with event information or a link to the event to Leslie West lwest@auglaizedd.org or mail to: Auglaize DD, Attn: Leslie, 20 East First St., New Bremen, OH 45869. Questions? Call (419) 629-1502 Ext. 101 (8 a.m. – 4 p.m. weekdays)

You will be contacted by no later than ten (14) days after we receive the application with the approval status. You will then need to submit a copy of your receipt of payment and/or registration confirmation to lwest@auglaizedd.org. Reimbursement will be processed within thirty (30) days of receiving a copy of your receipt of payment and/or a copy of your registration confirmation.

1. Agency Independent Name _____

2. Address:

Address: _____

City: _____ State: _____ ZIP: _____

3. Telephone Number(s)

(____) _____ - _____ (____) _____ - _____

4. Email

_____ @ _____



Auglaize DD

County Board of Developmental Disabilities

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5. Have you received funds from the Auglaize DD personal Development Grant program in the past 12 months?

Yes No.

Please select one of the following.

Training Individual accompaniment to event Supplies for Individual Served Other

If Supplies or Other Please explain.

6. How is this relevant to the individual as it pertains to the goals in their ISP? (If seeking reimbursement for training cost please disregard)

7. Cost Reimbursement Requested

Event Registration \$ _____ Hotel \$ _____ Supplies \$ _____

Other \$ _____

8. Certification Statement

By signing my name below, I confirm that all of the information provided above and in the accompanying documents (if any) is true and correct to the best of my knowledge. I also understand that if approved I must pay all registration fees and provide supporting documentation of such payment prior to receiving payment of said reimbursement.

Signature: _____ Date: _____

Office Use Only

Approved

Denied

Renee Kohler
Superintendent, Auglaize DD

Date