FAIRFIELD COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

PROVIDER INFORMATION FORM

Use this form to notify Fairfield DD of your interest in providing services in Fairfield County.

Date: _____

Provider/Agency Name:		
DODD Contract #:	Website:	
Street Address:		
City:	State:	Zip Code:
Office Phone:	Cell:	Fax:
Contact for MUI/UI's:		Email:
Contact for Provider Search emails:		Email:
Number of years providing services:		

Is your agency also certified by the Ohio Dept of Medicaid as a Home Health Agency? Yes:☐ No:☐
Does your agency provide Private Duty Nursing through Medicaid? Yes:☐ No:☐
Do you or your staff have DODD Medication Administration Certification? Yes:☐ No:☐
Agencies Only: Do you have an RN on staff who can delegate nursing tasks? Yes:☐ No:☐

Requests for Providers are found at
www.fairfielddd.com/rfp

Return Form to Tina Smith at tsmith@fairfielddd.com