FAMILY SUPPORT GOODS AND SERVICES REQUEST

COUNTY : _____

Revised 7-1-21

Date of Request: Individual Requesting: Phone: For (Individual Name): Address: Phone: Date of Birth: Email address: ***Do you own or rent your home?	*FOR OFFICE USE ONLY* PLEASE LEAVE THIS SECTION BLANK* Check Payable to: Address: Amount: Please return to: Family Support Coordinator Pineland BHDD Phone: (912)654-8020 Fax: (912)654-3050

Please provide a short description of the item/service you are request ng as well as an estimated price. (please include any item numbers, web addresses, etc.

The goal of Family Support is to sustain and enhance the quality of family/home life so that the individual with developmental disabilities can remain within a nurturing family in his/her home. Please provide a short description of how this item will make a positive difference in the life of the person with a disability as well as the lives of all family members.

Have there been any changes in services received from other sources since your application for Family Support was submitted to the region? Yes ☐ No ☐
If yes please provide explanation below:

_____ declare that the above requested items are not made available to me, or to my family though any other source.

Signature of Applicant/ Guardian _____ Date _____

Please do not write below this line.For Office Use Only.

Approved ☐ Denied ☐ Family Support Coordinator: _____ Date _____
Approved ☐ Denied ☐ Financial Department: _____ Date _____
If denied, state reason here:

Expense Account number: _____ CC type and #: _____

Date Paid: _____ Check #: _____

DBHDD

Family Support Services Application

Thank you for app ying for funds through the Georgia State Funded Family Support Program, Please note that State Funded Family Support funds are intended to be used as a last resort and you should utilize other programs before applying for this program. Please print clearly and fill out all pages, including your signature at the end of the application. Any application not completed in full will not be considered.

Section I: Demographic Information.

Date of Application:_____

Individual Name _____

Social Security Number:_____

Gender:_____Male_____Female__DOB:_____Age:_____

Race (optional)

☐ American Indian or Alaskan Native
☐ African American
☐ Multi-Racial/Ethnic Group
☐ Asian or Pacific Islander
☐ Caucasian/Anglo
☐ Other:_____

Ethnicity (optional)

☐ Not Hispanic
☐ Hispanic or Latino

Insurance Information

Private:_____ Public (Medicaid) #:_____

Family member/GuardianName:_____

Relationship to the Individual:

Legal Guardian of the Individual (Parent of a Minor Child/Guardian of an Adult Individual

Mailing Address:_____ County of Residence:_____

Mailing Address:_____ Phone:_____

City, State, Zip:_____ Email:_____

Section II: Diagnaostic Information

Developmental Disability Diagnosis:

Check which of the following disability categories is most relevant to the identified individual:

☐ Autism Spectrum Disorder
☐ Intellectual Disability
☐ Cerebral Palsy
☐ Muscular Dystrophy
☐ Neurological Impairment (Prior to age 22)
☐ Developmental Delay (0 — 8)
☐ Traumatic Brain Injury (Prior to age 22)
☐ Other:_____

Age at Time of Diagnosis:_____

Supporting Documentation:

Documentation of Diagnosis is required. Please attach a copy of the most recent psychological evaluation, Individual Education Plan (IEP), and/or any other evaluations/documentation with diagnostic information. Failure to provide supporting documentation will result in the application not being considered.

Check the supporting documentation attached to this application:

☐ DBHDD I&E Assessment ☐ Social Security Disability Determination (SS)
☐ School IEP ☐ Medical Verification
☐ Psychological Evaluation ☐ Other:_____

Section III: Current Service Information

Please check all current services that the identified individual is receiving:

☐ New Options Waiver (NOW)
☐ Currently on DBHDD Planning List
☐ 1CWP
☐ CCSP
☐ Deeming Waiver (Katie Beckett)
☐ Vocational Rehabilitation
☐ Food Stamps
☐ Individual Education Plan (IEP)
☐ ADRC-Options Counseling
☐ Comprehensive Waiver (COMP)
☐ SOURCE
☐ GAPP
☐ DBHDD State Funded Services
☐ Child Care Assistance (CAP)
☐ Adoption Assistance
☐ Social Security Disability (SSD1):
☐ Other:_____
☐ Other:_____

Please check all current services that the identified individual is receiving:

☐ Family ☐ Friends ☐ Church ☐ Social Groups ☐ Coworkers ☐ Support Group

☐ Other (please describe)_____

Section IV: Services Needs/Requests

From the list below, please check the services/goods your family has identified as needing:
(After your application has been approved, an assessment will be conducted to determine which services/goods will be awarded based on need and available funding.)

☐ Respite Care	☐ Environmental Modifications	☐ Exceptional Disability Related Livint Costs
☐ Community Living Support	☐ Specialized Equipment/Assistive Technolo	☐ Transportation Reimbursement
☐ Community Access	☐ T erapeutic Services	☐ Vehicle Adastation Services
☐ Supported Employment	☐ Counseling	☐ Child Day Care/After-School Services
☐ Dental Services	☐ Parent/Family Training	☐ Other Family Support Services
☐ Medical Care	☐ Specialized Nutrition	☐ Recreation/Social Community Integration Activities
☐ Vision Care	☐ Supplies	☐ Financial and Life Planning Assistance
☐ Specialized Clothing	☐ Incontinent Supplies	☐ Behavioral Consultation and Support
☐ Specialized Diagnostic Services		

Are the services/goods identified above accessible through other sources? Yes ☐ No ☐
Have the services/goods identified above been denied through other sources? Yes ☐ No ☐

Services/Goods Requested

Describe the benefit to the family if the services and goods above were funded:

_____
_____
_____
_____

DBHDD

Section Y:Agreement Section

I understand to be eligible for the Family Support Program the individual/applicant must be diagnosed with a developmental disability prior to the age of 22 and live in a family member's home. I hereby confirm that the information given at the time of application is true and accurate to the best of my knowledge.

Individual's Signature (If over 18 years of age)	Date
Individual's Printed Name	
	Date
Parent/Legal Guardian's Signature (If under the age of 18)	
Parent/Guardian's Printed Name	

DBHDD

Individualized Family Support Services
Application

For Agency/Provider Office Use Only

Section VI.: Eligibility Review and Determination

Individual's Name:_____

Date Completed Application Received:_____

Disposition for Family Support:

( ) Eligible For Family Support Services (Forward Application and Supporting Documents to the Regional RSA)

( ) Ineligible For Family Support Services

Provider Agency - Name:_____

Provider Staff - Name:_____

Title:_____ Contact Number:_____

E-Mail Address:_____

Provider Staff- Signature:_____ Date:_____

Section VI:

For Regional Office Use Only

Date Application Received
Date Application Reviewed:_____

Disposition for Family Support:
☐ Yes Eligible Status Verified:

☐ No - State the reason:

_____

_____

Provider:_____

Date of Notification:_____

Regional Staff's Name:_____ Title:_____

Regional Staff's Signature:_____ Date:_____

DBHDD

FAMILY SUPPORT SERVICES AGREEMENT

This is an agreement between the Individual and his/her family (as defined in the Family Support Policies) and the Provider/Agency regarding Family Support Services.

Agreement Start Date: _____ **Agreement End Date:** _____

INDIVIDUAL/ APPLICANT INFORMATION

Individual Name: _____

Individual Date of Birth: _____

Individual Social Security Number: _____

Individual Address: _____

Street Address: _____

Street Address: _____

City, State, Zip: _____

Individual Phone Number: _____

Name of Family Member: _____
(Person Applying on behalf of Individual)

Relationship to Individual: _____

Family Member's Address: _____

Street Address: _____

Street Address: _____

City, State, Zip: _____

Check if Same as Individual ☐

Family Member's Phone Number: _____

Check if Same as Individual ☐

PROVIDER INFORMATION

Family Member's Phone Number: _____

Provider/Agency Address: _____

Street Address: _____

Street Address: _____

City, State, Zip: _____

Provider/Agency Phone Number: _____

Provider/Agency Fax Number: _____

DBHDD

Individual/Applicant Family Support Services Acknowledgements:

Initials	I, as the Individual/Applicant attest and agree with the following statements:
_____	Attests that the Individual is residing in the family home within the community or the Family Support funds are to be used to prepare the home and the family for the return of the Individual (i.e., member with the developmental disability) from alternate care placement
_____	Understands and acknowledges that Family Support Services are neither an entitlement nor a grant and are provided as services to assist in maintaining a cohesive family unit and to assist the Individual to live at home in the community.
_____	Understands that a determination of eligibility for Family Support Funding does not guarantee receipt of f unding for such services/goods and is based on the availability of the Provider Agencies funding for Family Support Services.
_____	Understands that a determination of eligibility for Family Support Services is not a determination of eligibility for other DBHDD Services, including, but not limited to, State Funded Services and the NOW and COMP Waivers.
_____	Understands and acknowledges that Family Support Services are provided only in the event that comparable services are not available and/or cannot be funded through other programs (including, but not limited to Medicaid, Medicare, charitable organizations, etc.)..
_____	Attests that the Individual and his/her family will seek other funding resources for similar or related services/goods, when such funding resources are identified as a payer of such services/goods.
_____	Understand and acknowledges that Family Support Services is a needs-based program.
_____	Understands and attests that services/goods requested are not available through the Individualized Education Plan (IEP) and protected by Individuals with Disabilities Education Act (IDEA), and the responsibility of funding through the Local Education Authority (LEA).
_____	Understands and acknowledges that funding levels may change without prior notification.
_____	Understands and acknowledges that all funding available through Family Support Services will be used solely for the purpose(s) documented on the Individual Family Support Plan (IFSP), and to benefit the Individual diagnosed with a Developmental Disability.
_____	Understands and acknowledges that all services and goods requested must be related to the developmental disability, and are requested for the sole purpose of assisting the family to stay together as a family unit and to assisting the individual to remain in the community setting.
_____	Understands and acknowledges that only the services/goods listed in the Individual Family Support Plan (IFSP) will be provided and such services/goods are limited to the rate, frequency, and funding identified. Any services/goods not listed on the Individual Family Support Plan are not eligible for funding and/orreimbursement
_____	Understands and acknowledges that Family Support funds cannot be advanced, unless with express prior approval, to the Individual, to the Individual's Family, or to any provider of services under any circumstances.
_____	Understands the continued need for Family Support Services will be re-evaluated no less than annually.

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_____ Understands and acknowledges that the Individual must present receipts or other documentation to verify any expenses for which the Individual requests payment or reimbursement, and that all requests for reimbursement must comply with Family Support Services Policy. Understands that all direct reimbursement requests must be pre-authorized by the provider and listed on the IFSP. Understands that any misrepresentations of expenses or other attempt to misappropriate these funds is strictly prohibited and is subject to legal action and will result in the lifetime restriction of receiving any future funds/services/goods through Family Support Services by the Individual

_____ Understands and acknowledges that any misrepresentation of Individual's needs, will result in immediate discontinuation of services, in the Individual's lifetime restriction of receiving any future funds/services through Family Support Services and the individual by the applicant will be responsible to paying back any funds received based on such misrepresentation(s) or misappropriation(s).
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_____ Understands and acknowledges that the Individual must provide supporting documentation v erifying Family Support Services as the payer of last resort, including but not limited to; i nsurance denials, lack of insurance coverage, verification of lack of funding from community-based resources.

_____ Understands and acknowledges that any Individual providing respite services as part of Family Support must receive kriar approval to providing any respite services. (Reimbursement for any S ervices provided prior to being approved, will not be eligible for funding under Family Support Services)

_____ Understands and acknowledges that Family Support funds may not be used to reimburse funds already spent by the family prior to applying and being approved for Family Support Services, and/or may not be used to reimburse/fund services that are not specifically listed on the IFSP.

_____ Understands and acknowledges that if the provider/agency determines that the annual funding amount will not be exhausted before end date of the Individualized Family Support Plan, the provider/agency has the right to reduce and/or remove funds without prior notification.

_____ Understands and acknowledges that recipients of Family Support Services program, as a non-entitlement program and are not eligible to file appeals for services/goods, and or changes to funding.

_____ Understands and acknowledges that families can only receive Family Support Services from one Provider/Agency at time. Families agree only to change Provider/Agency with justification regarding service needs and cannot change agencies based on funding limits only. Transfers during the fiscal year must be reviewed and approved by the Regional Field Office.

_____ Agrees to utilize Family Support Services in compliance with all applicable policies, including the requirements for service providers.

_____ I verify that I have provided complete and accurate information to Provider / Agency regarding Individual's efforts to obtain services through other programs, and regarding and Individual's r esources and needs, and that Family Support Services is the payer of last resort on all goods/services listed on the Individualized Family Support Plan,

Family Support Services Agreements:

The Provider agrees as follows:

1. Provider will develop an individual Family Support Plan (IFSP) for the Individual/ Applicant. Provider will develop the IFSP in consultation with Individual/ Applicant.
2. Provider will designate a Family Support Coordinator as a single point of contact to work with Individual/Applicant and Family in obtaining Family Support Services.
3. Provider will review the IFSP annually, and revise based on resources or needs.
4. Provider will inform the Individual/Applicant in writing of Applicant's rights to participate in the IFSP and IFSP reviews, and to review a denial, discontinuance, or reduction in benefits.

Both parties agree as follows:

1. The Provider and Individual/ Applicant and Family will sign both copies of this agreement and return one signed copy to the appropriate DBHDD Regional Office. A copy will be kept on file by the Provider for DBHDD review as requested.
2. This Agreement contains the entire agreement between the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties. This Agreement does not preclude the parties from entering into other agreements with third parties.
3. This Agreement may not be amended or modified except in writing signed by both parties.
4. The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.
5. This Agreement is a required part of the Individual Family Support Plan; no Family Support funds may be expended prior to both parties' signing this Agreement.
6. This agreement is only active for a period of one year and must be completed annually to continue Services.

Signatures:

By signing I agree and acknowledge that all information provided to the Family Support Services Provider/Agency, and that I am in agreement with the above Family Support Agreements and will comply with all State and Provider/Agency request for additional documentation. I am in agreement to comply with all Family Support Services Policies.

Individual/Applicant Signature	Print	Date
Family Member Signature	Print	Date
Family Support Coordinator Signature		Date

Name (Individual receiving services)_____Date of Birth _____

Please complete this questionnaire to the best of your ability, and sign. This will assist in developing your individuals Family Support Plan for the Fiscal Year, and will determine his/her service categories and funding allotments.

1. What makes your individual happy? What makes him/ her smile? (this can be favorite food, places, people, things)

2. What are your hopes and expectations for you individual? What do you want to be sure they have access or exposure to?

3. Do you ever get stressed out and feel overwhelmed with caring for your individual? If so, explain what your stressors may be.

4. Family dynamics- Who are the members currently living in the household Ex: brother, sister, mother, father, aunts, grandmother/father, etc)

5. What activities does your individual, or family as a whole currently take part In outside of the home?

6. Do you ever find yourself paying out of pocket expenses related to medical, dental or vision care?

7. Does your individual require any type of specialized clothing as a result of his/ her disability? If yes, explain.

8. Would your individual benefit from taking part in more activities in the community? Please list activities he /she may be interested in.

9. Would your family benefit from structural changes made to your home which would allow more accommodation to his/her needs? (fencing for flight risks, wheelchair ramps, door widening, bathroom modifications, etc.) Explain.

10. Would your individual benefit from any assistive technology (if not school age) or other specialized equipment? Note: School age children should be provided assistive technology needs through their IEP.

11. (If not school age) Would your individual benefit from any type of therapeutic services such as physical, occupational or speech therapy? Counseling (family or individual)? Note: School age children should be provided therapies and counseling needs through their IEP.

12. Has your individual been prescribed any type of specialized nutrition such as Ensure, PediaSure or Boost? Does your individual use a feeding tube? If so, Is your individual receiving this supplement through any other source such as Medicaid or other source?

Type	Frequency (how many are prescribed a day)	Provided by another source (such as Medicaid or Private Insurance)
		___Yes☐ No☐

13. Does your individual use any type of incontinence supply (diapers, wipes, gloves, chux, etc)? If so, please list specific brand/ size of diapers/ wipes/ chux/ gloves and how many of each are used in a typical day. If your individual uses any other incontinence supplies not listed below, please add In available spaces.

	Circle one	Preferred Brand/ Type	Weight	Hip Measurement	Size	How many are used in a typical day	Provided by any other source
Diapers	Yes☐ No☐						☐Yes ☐No
Pull-Ups	Yes☐ No☐						☐Yes ☐No
Wipes	Yes☐ No☐						☐Yes ☐No
Chux (underpads)	Yes☐ No☐						☐Yes ☐No
Gloves	Yes☐ No☐						☐Yes ☐No

14. Have you ever been unable physically to take care of housekeeping needs?

15. Do you ever travel over 100 miles round trip to transport your individual to appointments or procedures?

16. Would you benefit from accommodations such as (lifts or ramps) made to your vehicle in order to transport your individual? If yes, explain.

17. Does your individual require after school care or daycare? If so, have you applied for CAPS? Note: In order for Family Support to provide assistance with child care/ after school care, we must have a CAPS denial letter on file. CAPS can be applied for online at www.compass.ga.gov

18. Do you have an email address? If so please list it here:

    _____

    _____have answered these questions honestly, and to the best of my ability. I understand that the answers to these questions will determine the level of support my individual receives through the Family Support Program. I understand that Family Support is not an entitlement program and is to be used only as a payer of last resort. All other funding options must be exhausted before utilizing Family Support Funding.

    Signature_____ Date _____