

## Individualized Family Support Application

Thank you for applying for funds through the Georgia Family Support Program. Please note that 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  
 American Indian or Alaska Native  Asian or Pacific Islander  
 African American  Caucasian/Anglo  
 Multi-Racial/Ethnic Group  Other: \_\_\_\_\_

Ethnicity  
 Not Hispanic  Hispanic or Latino

Insurance Information  
Private: \_\_\_\_\_ Public (Medicaid) #: \_\_\_\_\_

Family/Caregiver Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship to the Individual: \_\_\_\_\_  
Legal Guardian of the Individual (Parent of a Minor Child/Guardianship of an Adult Individual)

Mailing Address: \_\_\_\_\_ County of Residence: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you want this person to continue living in your home? Yes  No

### Section II: Diagnostic Information

#### Developmental Disability Diagnosis:

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

Autism Spectrum Disorder  Neurological Impairment (Prior to age 22)  
 Intellectual Disability  Developmental Delay (0 – 8)  
 Cerebral Palsy  Traumatic Brain Injury (Prior to age 22)  
 Muscular Dystrophy  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
- ICWP
- 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
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**Section IV: Services Needs/Requests**

**Functional Assessment: (Must be completed)**

Code: NA = Not Applicable

- I = Independent
- S = Needs Supervision (cues, coaxing, prompting)
- Min = Minimum Assistance (performs 75% or more of task)
- Mod = Moderate Assistance (performs 50%-74% of task)
- Max = Maximum Assistance (performs 25%-49% of task)
- T = Total Assistance (performs less than 25% of task)

Scale	Assessment Area	Description
	Self-Care	(ex. Feeding, Grooming, Bathing, Dressing, Toileting, Bladder/Bowel Management, etc.)
	Mobility/Locomotion	(ex. Assistance with transfers, use of wheelchair, crutches, walkers, etc.)
	Communication	(ex. Comprehension, Verbal Expression, Non-Verbal Expression, Speech, etc.)
	Psychosocial	(ex. Social Interactions, Emotional Status, Adjustment to limitations, employability, etc.)
	Cognitive Functioning	(ex. Problems Solving, Memory, Safety Judgment, etc.)
	Medical/Physical	(Therapy Services [Occupational, Physical, Speech], Medications, Seizure Management, Colostomy Care, etc.)
	Behavioral	(ex. Assaultive, Self-Injurious, Behavioral Outbursts, Wandering/AWOL, etc.)
	Legal	(ex. Criminal Charges, Legal Interactions, Incarceration, etc.)
	Aging	(ex. Dementia, Alzheimer's, Life Planning, etc.)
	Co-Occurring	(ex. Mental/Health Diagnosis or Addiction Diagnosis)

**Placement Issues**

Are you currently looking for out of home placement?

Yes  No

If "Yes", what type of out of home placement?

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**Services/Goods Requested**

*Please describe the services/goods in which the identified individual needs to assist with maintaining placement in the family home and/or community (Indication of need does not guarantee funding):*

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

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**Section V: Agreement Section**

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

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Printed Name

**Individualized Family Support 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: \_\_\_\_\_

## FAMILY SUPPORT SERVICES AGREEMENT

This is an agreement between the Family, on behalf of the Identified 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 AND APPLICANT INFORMATION

Individual's Printed Name: \_\_\_\_\_

Individual's Date of Birth: \_\_\_\_\_

Individual's Social Security Number: \_\_\_\_\_

#### Individual's Address

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Individual's Phone Number: \_\_\_\_\_

Printed Name of Applicant:  
(Person Applying on behalf of individual)

Relationship to Individual: \_\_\_\_\_

#### Applicant's Address

Check if Same as Individual

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Applicants' Phone Number: \_\_\_\_\_

Check if Same as Individual

### PROVIDER INFORMATION

Provider/ Agency Name: \_\_\_\_\_

#### Provider/Agency Address

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Provider/Agency Phone Number: \_\_\_\_\_

Provider/Agency Fax Number: \_\_\_\_\_

**Individual/Applicant Family Support Services Acknowledgements:**

**Initials**      **I as the Individual/Applicant attest and agree with the following statements:**

\_\_\_\_\_ The individual with a developmental disability is residing in the home, or if the Family Support funds are to be used to prepare the home and the family for the return of the member with a developmental disability from an 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 Family Support Funding in a non-entitlement program, and that a determination of eligibility does not guarantee funding of services/goods.

\_\_\_\_\_ Understand 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, NOW, and COMP Waivers.

\_\_\_\_\_ Understand that individuals that are receiving the following services are **not eligible** to receive Family Support Services: New Options Waiver (NOW); Comprehensive Supports Waivers (COMP); Inpatient Hospitalization; Skilled Nursing Facilities; Individuals living in Community Living Arrangements and Children, 19 years and younger, that are in DFCS custody, and are in Foster Care placement in an approved foster home operating under a licensed Child Placing Agency.

\_\_\_\_\_ Understand and acknowledges that Family Support services are provided only in the event that such services are not available or cannot be funded through other programs (including but not limited to Medicaid, Medicare, charitable organizations, etc.).

\_\_\_\_\_ Attests that the family will seek other funding for services/goods, when they are identified as a payor of services.

\_\_\_\_\_ Understand and acknowledges that Family Support Services is a needs based program.

\_\_\_\_\_ Understand and acknowledges that services/goods requesting 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).

\_\_\_\_\_ Acknowledges that no other resources are available for the services the Applicant has requested as Family Support.

\_\_\_\_\_ Understands and acknowledges that funding levels may changes 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, and to benefit the individual diagnosed with a Developmental Disability Diagnosis.

\_\_\_\_\_ Understands and acknowledges that all services and goods requested must be disability related and for the sole purpose of assisting the family to stay together as a family unit, and the individual to remain in the community setting.

\_\_\_\_\_ Understands and acknowledges that only the services/goods listed on the Individual Family Support Plan will be provided at the rate, frequency, duration, and funding limit identified. Any services/goods not listed on the Individual Family Support Plan are not eligible for funding and/or reimbursement.

\_\_\_\_\_ The Applicant understands and acknowledges that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.

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Understands the continued need for Family Support services will be re-evaluated no less annually.

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Understands and acknowledges to provide supporting documentation for the need of services and goods, including but not limited to prescriptions, receipts, etc.

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Understands and acknowledges that he/she must present receipts or other documentation to verify any expenses for which he/she requests payment or reimbursement, and that all request 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 applicant and the individual.

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Understands and acknowledges that any misrepresentation of Applicant's/ Individual's needs, resources, efforts to obtain services elsewhere, expenses incurred as part of the Family Service Plan and any attempt to misappropriate Family Support funds will result in immediate discontinuation of services, in the lifetime restriction of receiving any future funds/services/goods through Family Support Services, by the applicant and the individual, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s).

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Understands and acknowledges to provide that supporting documentation verifying Family Support Services is the payor of last resort, including but not limited to; insurance denials, lack of insurance coverage, verification of lack of funding from community based resources.

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Understands and acknowledges that any individual providing respite services as part of Family Support must be on a region maintained "List of Approved Respite Providers" prior to providing any respite services, and must meet all the requirements for Respite Services Provider, as identified in Family Support Policy. (Reimbursed for any services provided prior to being approved, will not be eligible for funding under Family Support Services.)

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Understands and acknowledges Family Support funds are not available to reimburse funds already spent by the family, prior to application, and/or that are not specifically listed on the Individual Family Support Plan.

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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.

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Understands and acknowledges that failure to utilize any funding allocated on the Individualized Family Support Plan will result in the potential for the individual to be placed on a waiting list for funding, until such time as funding becomes available.

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

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Understands and acknowledges specific guidelines regarding distribution of funds may vary from agency to agency within the state.

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Understands and acknowledges that families can only receive Family Support Services from one Provider/Agency at time. Families agree only change Provider/Agency with justification regarding service needs justification, and cannot change agencies based on funding limits only.

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

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I verify that I have provided complete and accurate information to Provider / Agency regarding Applicant's and Individual's efforts to obtain services through other programs, and regarding Applicant's and Individual's resources and needs, and that Family Support Services is the payor 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 Applicant and Individual. Provider will develop the IFSP in consultation with Applicant and to the extent possible, with the Individual.
2. Provider will designate a Family Support Coordinator as a single point of contact to work with Applicant and Individual in obtaining Family Support.
3. Provider will review the IFSP annually, and at such time as there has been a significant change in Applicant's/ Individual's resources or needs.
4. Provider will inform 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 Applicant 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 State Review, as needed.
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 will 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 is true and correct 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 \_\_\_\_\_

\_\_\_\_\_ Date

Family Support Coordinators Signature \_\_\_\_\_

\_\_\_\_\_ Date

Family Support Coordinators Name Print \_\_\_\_\_