Individualized Family Support Application (Revised May 2011)

Section I: Demographic Information

Applicant Name: _____Date of Application: _____

Medicaid #: _____Date of Birth: _____

Gender (Male or Female): _____Social Security Number: _____

Family/Caregiver Name _____

Phone #: Day: _____Evening: _____Other: _____

Address: _____City: _____

State: _____Zip Code: _____County: _____

Race/Ethnicity: ( ) American Indian or Alaska Native ( ) Asian or Pacific Islander ( ) Black or African American (Not Hispanic) ( ) Hispanic or Latino ( ) White (Not Hispanic)

( ) Multi-Racial/Ethnic Group ( ) Other

Section II: Diagnostic Information

Developmental Disability Diagnosis:

_____

Age at Time of Diagnosis: _____

Supporting Documentation Verifying Disability (Check the Documentation That Applies and Attach a Copy of the Documentation to This Application):

___DD I&E Assessment ___Adaptive Behavior Score
___Psychological Evaluation ___Functional Limitations
___School IEP ___Medical Verification
___IQ Score ___Social Security Disability Determination

(SS Determination is only acceptable if criteria for eligibility [ID/DD Status] is noted)

___Other: _____

Section III: Current Service Information

1. **Is this person currently enrolled in a Medicaid waiver program: ( ) Yes ( ) No**
2. **If "Yes", please check the appropriate Medicaid waiver program: ( ) NOW ( ) COMP**
   ( ) ICWP ( ) SOURCE ( ) CCSP ( ) GAP ( ) Katie Beckett ( ) GIA
3. **List the Medicaid waiver services that are currently received:**

   _____

   _____
4. **Have these waiver or other resources been exhausted? ( ) Yes ( ) No**
5. **Do you want this person to continue living in your home? ( ) Yes ( ) No**
6. **Are you looking for out of home placement? ( ) Yes ( ) No**
7. **If "Yes", what type of out of home placement? _____**

Section IV: Agreement Section

I hereby confirm that the information given at the time of application is true to the best of my knowledge.

Responsible Party Signature: _____

Responsible Party Printed Name: _____

Relationship: _____Date: _____

Appendix III
FAMILY SUPPORT AGREEMENT

_____("Applicant") has submitted an application on behalf of the family of _____("Individual") for Family Support services.

The View Point Health ("Provider"), a Family Support Provider / Agency contracting with DBHDD Region 3, has agreed to provide certain services. This is an agreement between Applicant, on behalf of Individual and his/her family (as defined in the Family Support Guidelines) and the Provider/Agency regarding Family Support Services. The family is eligible only if the member 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.

Applicant agrees as follows:

The Applicant understands 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.)

The Applicant has 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. The Applicant represents that no other resources are available for the services the Applicant has requested as Family Support.

The Applicant represents that all money received through Family Support services will be used solely for the purpose(s) documented on the Applicant's Individual Family Support Plan. The Applicant understands and acknowledges that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.

The Applicant understands and acknowledges that he/she must present receipts or other documentation to verify any expenses for which he/she requests payment or reimbursement. Any misrepresentations of expenses or other attempt to misappropriate these funds is strictly prohibited and is subject to legal action.

The Applicant 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, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s).

Applicant 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. (They cannot be reimbursed for any services provided prior to being approved.)

Applicant 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. The continued need for Family Support services will be re-evaluated no less annually.

The Applicant agrees to use the Family Support services in compliance with all applicable guidelines (Attached hereto as Annex B).

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 appeal 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 of 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.
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 terminate upon written notice of either party.

Individual's Printed Name and Date of Birth: _____

Printed Name of Applicant: _____

Relationship to : _____

Signature of Applicant: _____

Date of Applicant's Signature: **Month:** _____ **Date:** _____ **Year:** _____

Applicant's Complete Address: _____

_____

_____

Applicant's Contact Telephone/Cell Number(s): _____/ _____

Email Address: _____

Name of Provider / Agency: View Point Health

Printed Name of Provider / Agency Official: Ashley Daniel

Title of Provider / Agency Official: Family Support Coordinator

Provider / Agency Official Signature: _____

Date of Official's Signature: **Month:** _____ **Date:** _____ **Year:** _____

Provider / Agency's Complete Address:

175 Kirkland Road

Covington, GA 30016

Provider / Agency 's Contact Telephone/Cell Number(s): 678-209-2597