Family Support Services Application

Thank you for applying 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

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

_____ 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: _____ Email: _____

Section II: Diagnostic 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
_____ School IEP
_____ Psychological Evaluation
_____ Social Security Disability Determination (SS)
_____ Medical Verification
_____ 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
_____ Social Security Disability (SSDI): _____
_____ Other: _____
_____ Other: _____

*Please check **all** sources of the individual's current natural support network:*

____Family _____Friends _____Church _____Social Groups _____Coworkers ____Support Group
____Other (please describe) _____

Section IV: Services Needs/Requests

Placement Issues

Are you currently looking for out of home placement? Yes _____ No _____

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

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 Living Costs
Community Living Support	Specialized Equipment/Assistive Technology	Transportation Reimbursement
Community Access	Therapeutic Services	Vehicle Adaptation 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 funding:

_____

_____

_____

_____

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. 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: _____