

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 _____ Asian or Pacific Islander

_____ African American _____ Caucasian/Anglo

_____ Multi-Racial/Ethnic Group _____ 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 _____ 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:

<input type="checkbox"/> New Options Waiver (NOW)	<input type="checkbox"/> Comprehensive Waiver (COMP)
<input type="checkbox"/> Currently on DBHDD Planning List	<input type="checkbox"/> SOURCE
<input type="checkbox"/> ICWP	<input type="checkbox"/> GAPP
<input type="checkbox"/> CCSP	<input type="checkbox"/> DBHDD State Funded Services
<input type="checkbox"/> Deeming Waiver (Katie Beckett)	<input type="checkbox"/> Child Care Assistance (CAP)
<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Adoption Assistance
<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Social Security Disability (SSDI): _____
<input type="checkbox"/> Individual Education Plan (IEP)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> ADRC-Options Counseling	<input type="checkbox"/> 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: InCommunity Atlanta

Provider Staff - Name: Nicole Brickhouse

Title: Family Support Manager Contact Number: 404-634-4222 ext. 365

E-Mail Address: nicole.brickhouse@gacommunity.org

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: _____