# ~~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: _____
- ☐ 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? _____

**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):*

*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 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: _____