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
_______ African American
_______ Multi-Racial/Ethnic Group
_______ Asian or Pacific Islander
_______ Caucasian/Anglo
_______ 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
_____ 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
______ 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):

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____

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____

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

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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: _____________