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: Gateway Behavioral Health Services

Provider Staff - Name: Verlena O. Hawkins

Title: Family Support Coor. Contact Number: 912-503-9748

E-Mail Address: vhawkins@gatewaybhs.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: _____

FAMILY SUPPORT SERVICES AGREEMENT

This is an agreement between the Individual and his/her family (as defined in the Family Support Policies) and the Provider/Agency regarding Family Support Services.

Agreement Start Date: _____ **Agreement End Date:** _____

INDIVIDUAL AND APPLICANT INFORMATION

Individual's Printed Name:

Individual's Date of Birth:

Individual's Social Security Number:

Individual's Address

Street Address: _____

Street Address: _____

City, State, Zip: _____

Individual's Phone Number:

Printed Name of Family Member:
(Person Applying on behalf of individual) _____

Relationship to Individual: _____

Family Member's Address

Check if Same as Individual

Street Address: _____

Street Address: _____

City, State, Zip: _____

Family Member's Phone Number:
Check if Same as Individual

PROVIDER INFORMATION

Provider/ Agency Name: _____

Provider/Agency Address

Street Address: _____

Street Address: _____

City, State, Zip: _____

Provider/Agency Phone Number: _____

Provider/Agency Fax Number: _____

Individual/Applicant Family Support Services Acknowledgements:

Initials	I, as the Individual/Applicant attest and agree with the following statements:
_____	Attests that the Individual is residing in the family home within the community or the Family Support funds are to be used to prepare the home and the family for the return of the Individual (i.e., member with the developmental disability) from alternate care placement.
_____	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.
_____	Understands that a determination of eligibility for Family Support Funding does not guarantee receipt of and funding for such services/goods.
_____	Understand that a determination of eligibility for Family Support Services is not a determination of eligibility for other DBHDD Services, including, but not limited to, State Funded Services and the NOW, and COMP Waivers.
_____	Understand and acknowledge that Family Support Services are provided only in the event that comparable services are not available and/or cannot be funded through other programs (including, but not limited to Medicaid, Medicare, charitable organizations, etc.).
_____	Attests that the Individual and his/her family will seek other funding resources for similar or related Services/goods, when such funding resources are identified as a payer of such services/goods.
_____	Understand and acknowledges that Family Support Services is a needs-based program.
_____	Understand and acknowledges that services/goods requested are not available through the Individualized Education Plan (IEP) and protected by Individuals with Disabilities Education Act (IDEA), and the responsibility of funding through the Local Education Authority (LEA).
_____	Understands and acknowledges that funding levels may change without prior notification
_____	Understands and acknowledges that all funding available through Family Support Services will be used solely for the purpose(s) documented on the Individual Family Support Plan (IFSP), and to benefit the individual diagnosed with a Developmental Disability.
_____	Understands and acknowledges that all services and goods requested must be related to the developmental disability and are requested for the sole purpose of assisting the family to stay together as a family unit, and to assisting the individual to remain in the community setting.
_____	Understands and acknowledges that only the services/goods listed in the Individual Family Support Plan (IFSP) will be provided and such services/goods are limited to the rate, frequency, and funding identified. Any services/goods not listed on the Individual Family Support Plan are not eligible for funding and/or reimbursement.
_____	Understands and acknowledges that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.
_____	Understands the continued need for Family Support Services will be re-evaluated no less than annually.

_____ Understands and acknowledges that the individual must present receipts or other documentation to verify any expenses for which the individual requests payment or reimbursement, and that all requests for reimbursement must comply with Family Support Services Policy. Understands that all direct reimbursement requests must be pre-authorized by the provider, and listed on the IFSP. Understands that any misrepresentations of expenses or other attempt to misappropriate these funds is strictly prohibited and is subject to legal action, and will result in the lifetime restriction of receiving any future funds/services/goods through Family Support Services, by the applicant and the individual.

_____ Understands and acknowledges that any misrepresentation of Individual's needs, will result in immediate discontinuation of services, in the Individual's lifetime restriction of receiving any future funds/services through Family Support Services and the Individual by the applicant will be responsible to paying back any funds received based on such misrepresentation(s) or misappropriation(s).

_____ Understands and acknowledges that the Individual must provide supporting documentation verifying Family Support Services as the payer of last resort, including but not limited to; insurance denials, lack of insurance coverage, verification of lack of funding from community based resources.

_____ 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. (Reimbursement for any Services provided prior to being approved, will not be eligible for funding under Family Support Services)

_____ Understands and acknowledges that Family Support funds may not be used to reimburse funds already spent by the family prior to applying and being approved for Family Support Services, and/or may not be used to reimburse/fund services that are not specifically listed on the IFSP.

_____ Understands and acknowledges that if the provider/agency determines that the annual funding amount will not be exhausted before end date of the Individualized Family Support Plan, the provider/agency has the right to reduce and/or remove funds without prior notification.

_____ Understands and acknowledges that failure to utilize any funding allocated on the Individualized Family Support Plan will result in the potential for the individual to be placed on a waiting list for funding, until such time as funding becomes available.

_____ Understands and acknowledges that recipients of Family Support Services program, as a non-entitlement program are not eligible to file appeals for services/goods, and or changes to funding.

_____ Understands and acknowledges specific guidelines regarding distribution of funds may vary from agency to agency within the state.

_____ Understands and acknowledges that families can only receive Family Support Services from one Provider/Agency at time. Families agree only to change Provider/Agency with justification regarding service needs justification, and cannot change agencies based on funding limits only.

_____ Agrees to utilize Family Support Services in compliance with all applicable policies, including the requirements for service providers.

_____ I verify that I have provided complete and accurate information to Provider / Agency regarding Individual's efforts to obtain services through other programs, and regarding and Individual's resources and needs, and that Family Support Services is the payer of last resort on all goods/services listed on the Individualized Family Support Plan.

Family Support Services Agreements:

The Provider agrees as follows:

1. Provider will develop an Individual Family Support Plan (IFSP) for the Individual. Provider will develop the IFSP in consultation with Individual and Applicant.
2. Provider will designate a Family Support Coordinator as a single point of contact to work with Individual and Family in obtaining Family Support Services.
3. Provider will review the IFSP annually, and revise based on resources or needs.
4. Provider will inform the Individual/Applicant in writing of Applicant's rights to participate in the IFSP and IFSP reviews, and to review a denial, discontinuance, or reduction in benefits.

Both parties agree as follows:

1. The Provider and Individual/Family 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 between 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. This Agreement does not preclude the parties from entering into other agreements with third 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 is only active for a period of one year, and must be completed annually to continue Services.

Signatures:

By signing I agree and acknowledge that all information provided to the Family Support Services Provider/Agency, and that I am in agreement with the above Family Support Agreements and will comply with all State and Provider/Agency request for additional documentation. I am in agreement to comply with all Family Support Services Policies.

Individual's Signature	Print	Date
Family Member's Signature	Print	Date
Family Support Coordinator's Signature	Print	Date
Family Support Coordinator's Name	Print	

Gateway BEHAVIORAL HEALTH SERVICES

Individual Name | Chart #

Social Security Number | Date of Birth

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
Division of Developmental Disabilities

I hereby authorize: To **Gateway Behavioral Health Services, 700 Coastal Village Drive, Brunswick, GA 31520**

To /Obtain from: From FRIENDS
(Name of Health care provider holding the information – releasing agency)

528 Golden Grove Lane, Richmond Hill, Ga. 31324
(Address)

the following type(s) of information from my records (and any specific portion thereof):.

All relevant information for the purpose of treatment

_____ *Initials* I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below)

_____ *Initials* I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus) and /or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.

1. *I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R. Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*
3. *I understand that my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization of the requested release of information.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for : (PLEASE CHECK ONE)*

☑ one (1) year. OR ☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time by sending written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me.

Date | Signature of Individual

Signature of Witness (Title or Relationship to Individual) | Signature of (check one): ☐ Parent ☐ Guardian

USE THIS SPACE ONLY IF CONSUMER WITHDRAWS AUTHORIZATION

Date this authorization is revoked by Individual | Signature of Individual or legally authorized Representative