

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

Functional Assessment: (Must be completed)

Code: NA = Not Applicable

- | | |
|---|---|
| I = Independent | Mod = Moderate Assistance (performs 50%-74% of task) |
| S = Needs Supervision (cues, coaxing, prompting) | Max = Maximum Assistance (performs 25%-49% of task) |
| Min = Minimum Assistance (performs 75% or more 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: _____