Individualized Family Support Application

Section I: Demographic Information

Individual Name: _____ Date of Application: _____
Medicaid #: _____ Date of Birth: _____
Gender (Male or Female): _____ Social Security Number: _____
Family/Caregiver Name _____
Phone #: Day: _____ Evening: _____ Other: _____
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ County: _____
Race/Ethnicity: ◯ American Indian or Alaska Native ◯ Asian or Pacific Islander ◯ Black or African American (Not Hispanic) ◯ Hispanic or Latino ◯ White (Not Hispanic)
◯ Multi-Racial/Ethnic Group ◯ Other

Section II: Diagnostic Information

Developmental Disability Diagnosis:
_____
Age at Time of Diagnosis: _____
Supporting Documentation Verifying Disability (Check the Documentation That Applies and Attach a Copy of the Documentation to This Application):

☐ DD I&E Assessment **☐ Adaptive Behavior Score**

☐ Psychological Evaluation **☐ Functional Limitations**

☐ School IEP **☐ Medical Verification**

☐ IQ Score **☐ Social Security Disability Determination (SS)**

Determination is only acceptable if criteria for eligibility [ID/DD Status] is noted)

☐ Other: _____

Section III: Current Service Information

1. **Is this person currently enrolled in a Medicaid waiver program: ◯Yes ◯No**
2. **If "Yes", please check the appropriate Medicaid waiver program: ◯NOW ◯COMP ◯ ICWP ◯SOURCE ◯CCSP ◯GAP ◯Katie Beckett ◯ GIA**
3. **List the Medicaid waiver services that are currently received:**

   _____

   _____
4. **Have these waiver or other resources been exhausted? ◯Yes ◯No**
5. **Do you want this person to continue living in your home? ◯Yes ◯No**
6. **Are you looking for out of home placement? ◯Yes ◯No**
7. **If "Yes", what type of out of home placement? _____**

Section IV: Agreement Section

I hereby confirm that the information given at the time of application is true to the best of my knowledge.
Responsible Party Signature: _____
Responsible Party Printed Name: _____
Relationship: _____ Date: _____

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Section V:

For Agency/Provider Office Use Only

Individual's Name:_____

Date 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 Reviewed: _____**

Disposition for Family Support:
Eligible Status confirmed: ◯ Yes

◯ No - State the reason: _____

_____

Regional Staff's Name: _____Title: _____

Regional Staff's Signature: _____Date: _____

Provider: **Date of Notification:**

For Office Use Only:
◯ Provider **◯ Regional Office**

Comments: