# B&B Care Services, Inc.
# Individualized Family Support Plan

## Family Support Documentation Checklist

Applicant Name: _____

Family Caregiver Name: _____

Contact Number: _____

Contact E-Mail: _____

- ❑ B&B Care Services Application and Individualized Family Support and Respite Plan
- ❑ Medical Information, Authorization of Emergency Treatment, and Release of Information
- ❑ DBHDD Family Support Application
- ❑ DBHDD Individual Family Support Agreement
- ❑ Consent for Release/Receipt of Information
- ❑ Affidavit of Lawful Presence in the United States, if applicable over the age of 18*
- ❑ Birth Certificate
- ❑ Proof of Guardianship, if applicable over the age of 18
- ❑ Verification of a Disability

PLEASE NOTE: DBHDD'S FAMILY SUPPORT PROGRAM IS A NON-ENTITLEMENT PROGRAM BASED ON FUNDING AVAILABILITY AND LEVEL OF NEED. DBHDD MAKES IT VERY CLEAR THAT THE **MAXIMUM ALLOWANCE PER FISCAL YEAR IS UP TO $3,000.00 FAMILY SUPPORT/$4,900.00 RESPITE**. NO INDIVIDUAL IS GUARANTEED THAT AMOUNT OF FUNDING. FAMILY SUPPORT IS PAYER OF LAST RESORT. INDIVIDUALS ON THE DBHDD NOW/COMP PLANNING LIST SHALL RECEIVE PRIORITY FOR FUNDING REQUEST. B & B CARE FAMILY SUPPORT PROGRAM IS BASED ON DBHDD'S CURRENT POLICIES & PROCEDURES. POLICIES & PROCEDURES CAN BE REVISED AT ANY TIME WITHOUT NOTICE.

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

Applicant Name:_____Gender:_____
Date of Birth:_____SSN:_____Medicaid #:_____
Address:_____City:_____State:_____
Zip Code:_____County:_____Region:_____Program:_____
Legal Guardian:_____(*Proof of Guardianship required if Age 18+*) ☐ Self Guardian
Family/Caregiver Name:_____Age of Primary Caregiver:_____
Phone Number: (*primary*)_____(*secondary*)_____(*other*)_____
Family/Caregiver/Individual E-Mail:_____
Primary Qualifying Diagnosis:_____Age at Diagnosis:_____
Other Diagnoses: _____

## Race/Ethnicity:

- ☐ African American or Black
- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino
- ☐ White (not Hispanic)
- ☐ Multi-Racial
- ☐ Pacific Islander or Asian
- ☐ Other

## Eligibility Criteria:

- ☐ Intellectual/Developmental
- ☐ 3 Years or Older
- ☐ Autism
- ☐ Desire to Continue in Family Home
- ☐ Currently Residing in a Family Unit

## Other individuals living in your home (excluding applicant):

| Name | Birthdate | Relationship to Applicant | Employed? |
|---|---|---|---|
| | | | ☐FT ☐PT ☐N/A |
| | | | ☐FT ☐PT ☐N/A |
| | | | ☐FT ☐PT ☐N/A |
| | | | ☐FT ☐PT ☐N/A |
| | | | ☐FT ☐PT ☐N/A |
| | | | ☐FT ☐PT ☐N/A |

Number of <u>other</u> family members with a disability:_____

Name of person:_____Disability:_____Relationship to Participant:_____

Name of person:_____Disability:_____Relationship to Participant:_____

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

## Education:

Name of school applicant attends:_____Grade:_____

☐ Self-Contained ☐ Inclusion ☐ General Education ☐ Homeschool ☐ Other

## Physical Description:

Height:_____Weight:_____Hair Color:_____Eye Color: _____

Does the applicant wear glasses: ☐ Yes ☐ No

**Is the applicant:**

☐ Ambulatory ☐ Verbal ☐ Non-Verbal ☐ Non-Conversational

## Person-Centered Description of Individual:

(Give a brief description of the individual requesting services. Include likes, dislikes, skills, interests, and behaviors.)

## Describe what the individual feels is important in life:

(Include specific hobbies, activities, friends, family members, etc.)

## Support Network:

☐ Family ☐ Friends ☐ Church
☐ Social Group ❑ Coworkers ❑ Support Group
☐ Other

Describe:

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

**Describe what you feel is important for the individual's quality of life:**

**Describe your family's current situation:**
(Please include details of your physical environment, neighborhood, caregiver employment, and any other pertinent information that describes your family's current situation.)

**Residence:**

| | | |
|---|---|---|
| ☐ Own | ☐ Brick | ☐ Single Family Residence |
| ☐ Rent | ☐ Vinyl | ☐ Townhome/Apartment |
| ☐ Purchasing | ☐ Other | ☐ Mobile Home |

Bedrooms:_____ Bathrooms:_____ Levels:_____ Fenced Yard: ☐ Yes ☐ No

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

## Current Service Information

Check All Services Currently Received

- ❑ New Options Waiver (NOW)
- ❑ DBHDD Planning List
- ❑ ICWP
- ❑ EDWP (SOURCE / CCSP)
- ❑ Deeming Waiver (Katie Beckett)
- ❑ Vocational Rehabilitation
- ❑ Food Stamps (Amount received monthly)
- ❑ Individual Education Plan
- ❑ ADRC- Options Counseling
- ❑ Comprehensive Waiver (COMP)
- ❑ Medicaid
- ❑ GAPP (Number of hours used monthly)
- ❑ DBHDD State Funded Services
- ❑ Child Care Assistance (CAP)
- ❑ Adoption Assistance
- ❑ SSDI/Survivor's Benefits, SSI (Amount received monthly)
- ❑ Easter Seals CHAMPIONS
- ❑ Other (Please specify) _____

**Current Services:** (Use the list above to identify all current services the individual is receiving.)

| Service/Waiver/Program | Funding Source | Description/Funding Level |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Is the individual currently on the Planning List? ☐ Yes ☐ No

If so, who is the Planning List Navigator? _____

Was the individual denied the NOW/COMP Waiver? ☐ Yes ☐ No

If so, why? _____

**Unmet Needs of the Individual:** (Services/goods needed related to the individual's diagnosis needing financial assistance.)

| Unmet Need | Monthly/Annual Cost | Justification of Need |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Additional Expenses for the Individual:** (Services/goods paid out of pocket for due to the individual's diagnosis.)

| Additional Expense | Monthly/Annual Cost | Justification of Need |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# Family Support Authorized Goods and Services

The following is a list of goods and services that may be purchased with Family Support funds either by a contracted provider or directly for a family depending on funding availability and approval of B&B Care Services, Inc. Family Support Coordinator or CEO.

**Family Support Respite Care**- A service designed to relieve a family/caregiver of physical or emotional stresses associated with the care of the member with a developmental disability by the provision of temporary care of the member with a developmental disability in or out of the home.

**Family Support Community Living Support**- An array of services to assist an individual with the developmental disability to perform activities of daily living.

**Family Support Community Access**- An array of services that support an individual with a developmental disability in being involved in their community, based on his/her needs, wants and preferences.

**Family Support Supported Employment**- Services to support individual to become gainfully employed and to maintain their employment in the community.

**Dental Services**- The full array of services designed to care for the teeth, oral cavity, and maxillofacial area, provided by or under the direct supervision of a licensed dentist.

**Medical Care**- Services provided by or under the direct supervision of a licensed physician or by other licensed or certified health care professionals, when ordered by a licensed physician.

**Vision Care**- A service designed to care for the eyes. Services are provided under the direct supervision of a licensed optometrist or ophthalmologist, which are not covered under any vision insurance public and/or private.

**Specialized Clothing**- Services that include the assessment of need, design, construction, fitting, and cost of an article of clothing, which is necessitated by the handicapping condition of the individual with developmental disability.

**Specialized Diagnostic Services**- Specific investigative procedures determined as needed by the family and interdisciplinary team are necessary to complete the assessment of needs of the individual with disabilities and/or family.

**Recreation/Social Community Integration Activities**- Activities and/or goods designed to support the participation of the individual with a developmental disability in recreation/social community integration activities in the home and/or community.

**Family Support Environmental Modifications**- Changes or repairs to the personal home of the family/caregiver that are designed to increase their ability to enhance the development/functioning, health, or well being of the individual with a developmental disability.

**Family Support Specialized Equipment**- Adaptive and therapeutic devices specifically prescribed to meet the facilitative needs of the individual with a developmental disability or devices and equipment needed by the family to better provide for the specific needs of the family member with a developmental disability.

**Therapeutic Services**- A direct intervention service provided by a licensed therapist aimed at reducing or eliminating physical manifestations of a developmental disability or in improving/acquiring specific skills precluded by the developmental disability.

**Counseling**- Services utilizing a varied number of specific psychosocial approaches by a licensed counselor for the individual with a developmental disability and/or his/her family.

**Parent/Family Training**- Information and training for parents/family members to enhance understanding and to better address the needs of the family member who has a developmental disability.

**Specialized Nutrition**- An array of services that include: assessment, planning, counseling, supervision, and provision of specific dietary, nutritional, and feeding needs of the individual with a developmental disability.

**Supplies/Incontinence Supplies**- Any number of items that may require frequent usage due to the individual's developmental disability. These supplies may not be specialized or specific to the needs of the individual with the developmental disability, but may be necessary to the on-going operation or maintenance of specialized devices or any number of items that are needed by the family to better provide for the disability specific needs of the family member with the developmental disability.

**Behavioral Consultation and Support**- Professional services which train and support the family in avoiding and/or responding appropriately to behaviors which may create barriers to the individual with a developmental disability and their ability to remain in the home and community.

**Financial and Life Planning Assistance**- Professional services which assist the family in planning for the future services and/or financial needs of the family member with a developmental disability.

**Exceptional Disability Related Living Cost**- This service is utilized to pay living expenses that are higher than normal due to the nature of the individual's developmental disability.

**Family Support Transportation**- Travel and travel related costs (including subsistence costs) associated with the receipt of a service identified in the plan and documented by the provider to be necessary to meet the needs of the family.

**Community Integration Transportation-** This service is utilized to pay transportation expenses related to improving and/or increasing access to the community, and community integration activities.

**Vehicle Adaptation Services**- These services include adaptations to the individual's or family's vehicle in order to accommodate the special needs of the individual with a developmental disability.

**Child Day Care/After School Services**- These services are specific to after-school programs or child day care costs at a licensed child care facility or a family's share of such costs for the individual with the disability.

**Other Family Support Services**- If a service or item does not fit the categories list, the provider submits a request for Other Family Support Services Funding Form with justification and supporting documentation for prior approval from the Regional Services Administrator for Developmental Disabilities or their designee prior to approving and/or providing the service for the individual and/or family.

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date: _____ Expiration Date: _____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

## Services/Goods Requested

Georgia Department of Behavioral Health & Developmental Disabilities's Family Support Program is a non-entitlement program based on funding availability and level of need. The annual maximum allowance is **UP** to $3,000.00 Family Support/$4,900.00 Respite Care per fiscal year. DBHDD makes it very clear that no individual and/or family is guaranteed that amount of funing. Individual's request who are currently on the NOW/COMP Planning List will take priority over all others. Requests are to be submitted to **FS@bandbcare.com** between the 1st and 15th of each month for services/goods needed for the following month. Caregiver is notified on or about the 25th of the month as to whether their request are approved.

1. Service/Good:_____Category:_____Amount: _____
   Measurable Goal: _____
   _____
2. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
3. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
4. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
5. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
6. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

# OFFICE USE ONLY

**Review of previous year Family Support Goods and Services:**

| Service/Good | Outcome/Achievement/Benefit of the Service/Good |
|---|---|
| 1 | |
| Measurable Goal Achieved: | |
| 2 | |
| Measurable Goal Achieved: | |
| 3 | |
| Measurable Goal Achieved: | |
| 4 | |
| Measurable Goal Achieved: | |

**Current year budget for your family:**

| Service/Good | Description/Justification | Other Sources Verified | Frequency/ Duration | Annual Cost |
|---|---|---|---|---|
| 1 | | | | |
| Measurable Goal: | | | | |
| 2 | | | | |
| Measurable Goal: | | | | |
| 3 | | | | |
| Measurable Goal: | | | | |
| 4 | | | | |
| Measurable Goal: | | | | |
| 5 | | | | |
| Measurable Goal: | | | | |
| 6 | | | | |
| Measurable Goal: | | | | |
| | | | Total Annual Budget: | |

Are the goods/services identified above accessible through other sources? ☐ Yes ☐ No

Have the goods/services identified above been denied through other sources? ☐ Yes ☐ No

If the goods/services have been denied, by which resources? (Include denial information)

☐ Group Insurance ☐ Medicaid ☐ School System ☐ Babies Can't Wait ☐ Community Action Groups

Other: _____

# STATE FUNDED RESPITE

B&B Care Services, Inc. has received a contract from the State of Georgia, Department of Behavioral Health and Developmental Disabilities for the Fiscal Year beginning July 1, 2023 for the purpose of procuring respite services for families who provide supports to individuals with Developmental Disabilities who are:

a. Currently living with the family; and,
b. The family desires for the individual to continue living with the family.
c. The purpose of respite service is to provide temporary relief of the caregiving responsibilities.

The State Funded Respite funding is separate from Family Support services. Respite services are individualized based upon the family's need and available state funding.

Funding is prioritized first by emergency situations, such as the death or illness of the primary caregiver, or other urgent, nonscheduled events. Secondly, funding is based upon a first come basis each month. Funding cannot be authorized in excess of one month at the time. Funding is not guaranteed each month and is limited to state funding availability.

Qualified providers are only those agencies that are approved by the Department of Behavioral Health and Developmental Disabilities and carry the required Department of Community Health, Office of Regulatory Services license to provide either in home supports our Alternative Living Supports. B&B Care Services must obtain vendor agreements with these agencies prior to the issuing of prior authorizations.
Caregivers have the responsibility for selecting, training, and supervising the DBHDD approved agency selected to be the respite provider on the specific needs of the individual to receive service.

State Funded Respite Scheduling:

a. Download the Respite service request form at www.bandbcare.com/family-support
b. Email: Please email the completed request form to **respite@bandbcare.com** by the 15th of the current month for service to be provided the next month. ***Request is limited to only one month in advance and will expire by end of the approved month.***
c. If approved, B&B staff will notify you and your chosen provider with a Prior Authorization (Voucher) that will confirm the date and hours authorized.
    a. All Respite Services scheduled directly with the provider without a Prior Authorization will be the financial responsibility of the Legal Guardian or parent.
    b. The caregiver has the responsibility for scheduling the respite service with the provider agency once the prior authorization is issued.

If you have any further questions, please feel free to contact our office via email at respite@bandbcare.com

*Thank you for the opportunity to work with you and your family.*

**B&B Care Services, Inc.**

**Individualized Family Support Plan**

Effective Date:_____ Expiration Date:_____

Applicant Name:_____ Primary Contact Name:_____

Phone:_____Email:_____

# B&B Care Services, Inc. Individualized Respite Budget

# OFFICE USE ONLY

## Review of previous year Respite Services:

| Service | Describe the Outcome/Achievement/Benefit of the Service/Good: |
|---|---|
| 1 Out of Home Respite | |
| Measurable Goal Achieved: | |
| 2 In Home Respite | |
| Measurable Goal Achieved: | |

## Current Year Projected Budget

| Service / Good | Description / Justification | Other Sources Verified | Duration/ # of Days | Annual Cost |
|---|---|---|---|---|
| 1 Emergency Respite | | | | |
| Measurable Goal: | | | | |
| 2 Maintenance Respite | | | | |
| Measurable Goal: | | | | |

**Please Initial:**

_____**I hereby confirm that the information given at the time of this plan is true to the best of my knowledge and that any untrue information or misrepresentation will be reported to the state DBHDD Offices and my family may be subject to repayment of all funds utilized on my family's behalf and may be subject to prosecution.**

_____**I understand that it is my duty to inform B&B Care Services, Inc. of any significant changes in needs or resources immediately and I have the right to participate in plan review at least annually and request changes as needed.**

_____**I attest that I was informed of my right to participate in the development of this Individualized Family Support Plan, and was given the ability to identify services and goods based on my/our family priority of needs for services/goods.**

_____**I understand that State Funded Respite is a non-entitlement program and that B&B Care Services, Inc. may not fund all the services and goods that I may request, and that funding levels can and might change from each funding year and are subject to funding limitations.**

_____ _____

**Responsible Party Signature** **Responsible Party Printed Name**

mother _____

**Relationship** **Date**

_____ _____

**B&B Care Services Representative Signature** **Date**

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

**Please Initial:**

_____I understand in consideration of my being allowed to participate in the program, I must obtain a voucher form from B&B Care Services, Inc. for services or any purchase of goods or services on behalf of my family.

_____I hereby confirm that the information give at the time of this plan is true to the best of my knowledge and that any untrue information or misrepresentation will be reported to the state DBHDD Offices and my family may be subject to repayment of all funds utilized on my family's behalf and may be subject to prosecution.

_____I understand that it is my duty to inform B&B Care Services, Inc. of any significant changes in needs or resources immediately, and I have the right to participate in plan review at least annually and request changes as needed.

_____I attest that I was informed of my right to participate in the development of this Individualized Family Support and/or Respite Plan, and was give the ability to identify services and goods based on my/our family priority of needs for services/goods.

_____I understand that Family Support is a non-entitlement program, may not fund all services and goods that are requested, and funding levels can and might change from each funding year and are subject to funding limitations.

_____I understand that each individual may only use one (1) Family Support Agency at a time and that I may not transfer enrollment to another Family Support Agency within one (1) year of beginning services with B&B Care Services, Inc. except in case of emergency.

_____ _____
**Responsible Party Signature** **Responsible Party Printed Name**

_____ _____
**Relationship** **Date**

_____ _____
**B&B Care Services Representative Signature** **Date**

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

## Service Agreement

### Description of Services (Please Initial)

## FAMILY SUPPORT:

____ **FAMILY SUPPORT COORDINATION:** Services to support the individual and family in multiple facets of life by linking them to needed services and resources.

____ **FAMILY SUPPORT:** Brokering of goods and services aimed at providing families with the very individualized support they need to continue to care for a family member with disabilities at home. The goal is to prevent crises that can result in the need for out of home placement.

____ **RESPITE:** A temporary break in the care taking responsibilities of a family member.

____ **PARENT/FAMILY TRAINING:** Information and/or training provided to parent/family member to enhance the understanding and address the needs of the family member with a disability.

## OTHER:

____ **CASE MANAGEMENT:** Those activities normally performed by a Certified Case Manager including, but not limited to, coordination of service delivery, evaluation of participant needs, evaluation and monitoring of services and determining and measuring outcomes.

____ **CONSULTATION:** Include, but not limited to, developing a person-centered plan of care, identifying available resources, providing information on the process of accessing services and providing assistance with future planning.

____ **SUPPORTED EMPLOYMENT:** Supports that enable participants with developmental disabilities to gain and maintain employment in a regular work environment.

____ **PREVOCATIONAL SERVICES:** Services to prepare individuals for paid/unpaid employment.

____ **COMMUNITY ACCESS:** Services provided to improve an individual's access to their own community.

____ **COMMUNITY LIVING SUPPORTS:** Individually tailored supports that assist with the acquisition, retention, or improvement of skills related to the individual continuing to reside in his or her own home or family home.

____ **ENVIRONMENTAL MODIFICATIONS:** Physical adaptations to the individual's home to ensure health, welfare, and safety or enable greater independence in the home.

____ **DURABLE MEDICAL EQUIPMENT:** Equipment consisting of devices, controls, appliances, etc. which enable participants to increase their ability to perform activities of daily living.

____ **MEDICAL SUPPLIES:** Supplies that consist of food supplements, specialized clothing, incontinence supplies, and other authorized supplies.

## CHARGES AND PAYMENTS FOR SERVICES:

____ **GEORGIA DBHDD FAMILY SUPPORT & RESPITE:** The state has allocated funding to B&B Care Services to assist in providing a variety of goods and services and supports to individuals with disabilities who have the desire to live in their own home.

____ **PRIVATE PAY:** You will be financially responsible for all or part of the cost of services. Payment arrangements must be made prior to service delivery.

____ **MEDICAID**

____ **VOCATIONAL REHAB**

____ **OTHER:**_____

**I, as the Individual/Applicant, attest to and agree with the following statements:** (Please Initial)

____ The individual with a developmental disability is residing in the home, or the Family Support funds are to be used to prepare the home and the family for the return of the member with a developmental disability from an alternate care placement.

____ I understand and acknowledge 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.

____ I understand and acknowledge that Family Support is a non-entitlement program, and that determination of eligibility does not guarantee funding of services/goods.

____ I understand and acknowledge 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 NOW or COMP Waivers.

____ I understand and acknowledge that Family Support services are provided only in the event that such services are not available or cannot be funded through other programs (including, but not limited, to Medicaid, Medicare, charitable organizations, etc.).

____ I attest that the family will seek other funding sources for services/goods when they are identified as payer of services.

____ I understand and acknowledge that Family Support Services is a needs-based program.

____ I understand and acknowledge that services/goods requested are not available through the Individualized Education Plan (IEP) and protected by the Individuals with Disabilities Education Act (IDEA) and are the responsibility of funding through the Local Education Authority. (LEA)

____ I understand and acknowledge that no other resources are available for the services the Applicant has requested through Family Support.

____ I understand and acknowledge that funding levels may change without prior notification.

____ I understand and acknowledge that all funding available through Family Support Services will be used solely for the purpose(s) documented on the Individual Family Support Plan, and to benefit the individual diagnosed with a developmental disability.

____ I understand and acknowledge that all services and goods requested must be disability related and for the sole purpose for assisting the family to stay together as a family unit, and the individual to remain in the community setting.

____ I understand and acknowledge that only the services/goods listed on the Individual Family Support Plan will be provided at the rate, frequency, duration, and funding limit identified. Any services/goods not listed on the Individual Family Support Plan are not eligible for funding and/or reimbursement.

____ I understand and acknowledge that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.

____ I understand and acknowledge the continued need for Family Support Services will be reevaluated no less than annually.

____ I understand and acknowledge I must provide supporting documentation for the need of services and goods, including, but not limited to, prescriptions, receipts, etc.

____ I understand and acknowledge that I must present receipts or other documentation to verify any expense for which I request payment or reimbursement, and that all request for reimbursement must comply with Family Support Services Policy. I understand and acknowledge that all direct reimbursement requests must be preauthorized by the provider and listed on the IFSP. I understand and acknowledge that any misrepresentation 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.

____ I understand and acknowledge that any misrepresentation of Applicant's/Individual's needs, resources, efforts to obtain services elsewhere, expenses incurred as part of the Family Service Plan and any attempt to misappropriate Family Support funds will result in immediate discontinuation of services, in the lifetime restriction of receiving any future funds/services/goods through Family Support Services, by the applicant and the individual, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s).

____ I understand and acknowledge I must provide supporting documentation verifying Family Support Services is the payer of last resort, including, but not limited to, insurance denials, lack of insurance coverage, and verification of lack of funding from community-based resources.

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

____ I understand and acknowledge that any individual providing respite services as part of Family Support must be on a region maintain "List of Approved Respite Providers" prior to providing and receiving respite services, and must meet all the requirements for Respite Services Provider, as identified in Family Support Policy. Reimbursement for any services prior to being approved will not be eligible for funding under Family Support Services.

____ I understand and acknowledge Family Support Funds are not available to reimburse funds already spent by the family, prior to application, and/or that are not specifically listed on the Individual Family Support Plan.

____ I understand and acknowledge 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.

____ I understand and acknowledge 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.

____ I understand and acknowledge that recipients of Family Support Services, as a non-entitlement program, are not eligible to file grievances for services/goods and/or to changes to funding.

____ I understand and acknowledge specific guidelines regarding distribution of funds may vary from agency to agency within the state.

____ I understand and acknowledge that families can only receive Family Support Services from one Provider/Agency at a time. I agree to only change Provider/Agency with justification regarding services needs and cannot change agencies based on funding limits alone.

____ I agree 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 Applicant's and Individual's efforts to obtain service through other programs and regarding Applicant's 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 Voucher Program Waiver and Release:** (Please Initial)

____ As a voluntary participant in the B&B Care Services' Respite and/or Family Support Voucher Program, I understand and acknowledge that B&B Care Services is not involved and has not been involved in any way with the selection of the Respite or Family Support provider or agency which will provide goods or services to my family members. I also understand and acknowledge that B&B Care Services makes no representation about the care provider or his/her capability or suitability.

____ I accept that it is my responsibility as a family member or guardian to select provider agencies that will provide goods and services to my family member. I understand that it is my responsibility also to determine the suitability of the provider or agency to provide adequate goods or services to my family member and to acquaint them with the particular needs of my family member. Therefore, on my own behalf and on behalf of my family, I freely and voluntarily accept all risk of personal injury and property damage arising from my family's participation in the program.

____ In consideration of my being allowed to participate in the program to receive a voucher for services or any purchase of goods or services on behalf of my family, I hereby release and discharge B&B Care Services and its officers, directors, employees, agents and successors, from any and all claims and demands whatsoever that I or my family may hereafter have for injuries or property damage arising or resulting from my and my family's participation in the program, all of which claims I hereby waive. I waive my and my family's right with the full knowledge that B&B Care Services will not compensate me or my family in any way for any losses or injury I or my family may sustain. I understand and agree that this waiver and release will be fully binding on me, all members of my family, our estates, and our heirs, and that neither any member of my family nor anyone claiming through me or any members of my family will have any legal right to assert a claim against B&B Care Services or its officers, directors, employees and agents, or any of their successors, related to me and my family's participation in the program.

_____ _____
**Responsible Party Signature** **Responsible Party Printed Name**

_____ _____
**Relationship** **Date**

_____ _____
**B&B Care Services Representative Signature** **Date**

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

## Participant's Rights and Responsibilities

B&B Care Services, Inc. is a family centered program that allows families and participants to assist in identifying their need for services and involves families and participants in service design and implementation. B&B Care Services, Inc. does not discriminate because of race, color, sex, creed, religion, age or national origin of the participant, family or provider.

**As a participant enrolled in B&B Care Services programs, you and your family have the right to:**

1. Not be discriminated against because of race, color, religious creed, disability, handicap, medical condition, ancestry, national origin, age, culture, education, language, socioeconomic status, gender identity, sexual orientation, sex or any protected status.
2. Participate voluntarily in the preparation of service or services to be provided and to receive adequate and appropriate care and services without discrimination and program planning that affects him/her.
3. Participate in the selection of the service delivery team.
4. Receive prompt and confidential services in the least restrictive environment available.
5. Receive person-centered services in conflict free environment.
6. Live and work in a setting integrated into the participant's larger natural community.
7. Access free interpretation services as needed.
8. Be informed of the benefits, risks, and/or side effects of all medications and treatment alternatives.
9. Be free from excessive medication.
10. Be promptly and fully informed in changes in the service plan and to participate in plan development and decision-making regarding the selection, direction, or changes and to receive person-centered services according to the plan.
11. Accept and refuse services.
12. Be fully informed of any charges for services.
13. Not to be neglected, abused, mistreated, or subjected to corporal punishment. To be free of restraints or seclusion, except as a last resort for safety.
14. Not be required to participate in research projects.
15. Manage his or her financial affairs. To keep or have access to participant's own money and personal effects, with limitation to safety. To access training on personal finance effects on Medicaid eligibility.
16. Receive, purchase, have and use personal property, including clothing.
17. Receive or refuse to receive scheduled and unscheduled visitors, communicate, associate, and meet privately with their family and persons of the individual's choice with due regard to Participant's privacy.
18. Reasonable access to a telephone and the opportunity to receive, refuse, and to make private calls with assistance when necessary.
19. Unrestricted mail privileges.
20. Vote if of age and be informed of your right to vote and be assisted in registering and voting.
21. Practice the religion or faith of the your choice. Pursue employment, education, and/or religious expression.
22. Be treated in such a manner to ensure the individual's safety, health and comfort and the right to be treated as an individual with his or her strengths, unique characteristics and needs acknowledged and respected. The right to have property and residence treated with respect.
23. Maximized amount of time, space and personal privacy in bedrooms, bathrooms, and during personal care consistent with age, level of functioning and delivery of services: the participant has the right to be treated respectfully and to have their property treated with respect
24. Confidentiality of all information and records and activities within legal limits.
25. Not be subjected to psychological, sexual, fiduciary, mental, or physical humiliation or abuse in any fashion and must be accorded respect and dignity at all times and shall not be exploited or threatened in any way.
26. Prompt and adequate medical treatment when needed.

27. Be informed in a timely manner if impending discharge, continuing care requirements and other available services if needed.
28. Obtain a copy of the provider's most recent completed report of licensure inspection and/or accreditation from the provider upon written request.
29. Access to accurate and easy to understand information with sufficient time to make decisions.
30. Choice of approved service provider(s) and team.
31. Be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.
32. Inspect and/or obtain a copy of his or her clinical record and protected health information, to request restriction of the uses and disclosures of his/her PHI, to request alternate means or location of communications or PHI, to correct or amend his/her PHI and to receive an accounting of disclosures of PHI. Receive a separate Notice of Privacy Practices about confidentiality of your PHI.
33. Consult participant's own physician or attorney; filing a complaint.
34. Know the administrator/supervisor of the program. The Administrator, Lynnette Bragg, supervises the program. The business phone number is 912-754-0817 or 855-754-0817. The business address is Post Office Box 1040, Springfield, Georgia 31329.
35. Submit complaints regarding treatment of care that is furnished or not furnished, without fear of discrimination, coercion, reprisal or retaliation to have them investigated within a reasonable period of time.

**All complaints may be submitted to the Administrator (Lynnette Bragg) of B&B Care Services at 912-754-0817 or 855-754-0817 or to Post Office Box 1040, Springfield, Georgia 31329. If the complaint is not resolved to your satisfaction, or if you prefer, you may contact the Department of Behavioral Health and Developmental Disabilities Regional Office Monday thru Friday 9 AM to 5 PM, Region 2 (706-732-7733) Region 5 (912-303-1670). Department of Community Health, 2 Peachtree St. NW, 31st Floor, Atlanta, 30303 (404-657-5726 or 404-657-5728), Georgia Advocacy Office in Atlanta, 150 E. Ponce de Leon Ave, Suite 430, Decatur, GA 30030 (404-885-1234 or 1-800-537-2329), or Governor's Office of Disability Services Ombudsman, 270 Washington St., 8th Floor, Suite 8087, Atlanta, GA 30334 (404-656-4261 or 1-866-424-7577).**

**As a participant of family member enrolled in B&B Care Services programs, you and your family have the responsibility to:**

1. Provide complete and accurate information to the best of your ability about you or your family member and their specific condition, the home situation and any events that may affect the needed services.
2. Assure that financial obligations are fulfilled as promptly as possible.
3. Be considerate and respectful of your provider and assure a safe work environment.
4. Notify the Agency of any changes in the participant's condition or any events that affect the applicant's service needs within 10 days.
5. Participate actively in decisions regarding individual health care and service/care plan.
6. Comply with agreed-upon care plans.
7. Notify the client's physician, service provider(s), and/or caregivers of any change in one's condition.
8. Be available to provider staff at scheduled times services are to be rendered.

_____ _____
**Responsible Party Signature** **Responsible Party Printed Name**

_____ _____
**Relationship** **Date**

_____ _____
**B&B Care Services Representative Signature** **Date**

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

## Health Information & Release

**PART I: To be completed by the Legal Guardian or Responsible Party prior to services being rendered**

| | | | |
|---|---|---|---|
| Preferred Name: | Gender: | DOB: | Age: |
| Address: | City: | County: | Zip: |
| Height: | Weight: | Race/Ethnicity: | Marital Status: |
| Religious Preference: | | Legal Status: (Guardian) | |
| Medicare Number: | | Medicaid Number: | |
| Other Insurance | | Payment Guarantor: | |

| | |
|---|---|
| Primary Physician: | Physician Contact Number: |
| Physician Address: | |
| Primary Dentist: | Dentist Contact Number: |
| Dentist Address: | |
| Preferred Hospital: | Hospital Contact Number: |
| Hospital Address: | |
| Preferred Pharmacy: | Pharmacy Phone: |
| Pharmacy Address | |

**Emergency contacts/Next of Kin (if minor or adjudicated, parent or legal guardian)**

| | | | |
|---|---|---|---|
| Name: | Relationship: | | ☐ Legal Guardian |
| Address: | | | |
| Telephone | Home: | Work: | Cell: |

| | | | |
|---|---|---|---|
| Name: | Relationship: | | ☐ Legal Guardian |
| Address: | | | |
| Telephone | Home: | Work: | Cell: |

**Allergies (if none specify NKA)**

| Type of Allergy | Specify Allergy |
|---|---|
| Medication | |
| Food | |
| Insect Bites/Stings | |
| Other Allergies | |

**All Medical Diagnoses, Chronic and/or Ongoing Medical Issues and Effect on Individual's Life**

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

**Functional Assessment:**

Scale: use scale below to rate
Min = Minimum Assistance (Performs 75% or more of tasks)
Mod = Moderate Assistance (Performs 50%-74% of tasks)
Max = Maximum Assistance (Performs 25%-49% of tasks)

Assessment Area: use code below that best fits
I = Independent
S = Needs Supervision (Cues, Coaxing, Prompting)
T = Total Assistance (Performs less than 25% of tasks)
N/A= Not Applicable

| Scale | Assessment Area | Please Provide 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 Interaction, Emotional Status, Adjustment to limitations, Employability, etc.) |
| | Cognitive Functioning | (Ex: Problem Solving, Memory, Safety Judgement, etc.) |
| | Medical/ Physical | (Ex: Therapy Services (Occupational, Physical, Speech), Medications Seizure Management, Colostomy Care, etc.) |
| | Behavioral | (Ex: Assaultive, Self-Injurious, Behavioral Outbursts, Wandering, etc.) |
| | Legal | (Ex: Criminal Charges, Legal Interaction, Incarceration, etc.) |
| | Aging | (Ex: Dementia, Alzheimer's, Life Planning, etc.) |
| | Co-Occurring | (Ex: Mental/Health Diagnosis or Addiction Diagnosis) |

**Additional Information Which Might Be Pertinent or Helpful to Know for an Alternate Caregiver:**

(Include behaviors, communication abilities, etc.)

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

**Current Medication Summary: List all medications currently ordered for the person.**

| Medication Name | Dosage/Route/ Frequency | Purpose of Medication | Ordered By | Original Date Ordered | Specific Concerns |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Describe Caregiver Assistance Needed to Attain and Take Medication:** (Check all that apply)

- ☐ Obtains Prescriptions and Refills
- ☐ Administers Medications
- ☐ Monitors for Side Effects
- ☐ Independent
- ☐ Needs Reminders
- ☐ Uses Pill Organizer, Alarm, etc. Please Specify: _____

| Illness/Surgery/Hospitalization | Date | Illness/Surgery/Hospitalization | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

**Level of Care:** (Check the level that describes individual)

- ☐ Mild support need and requires little to no support for medical or behavioral conditions.
- ☐ Modest-to-moderate support needs and requires little to no support for medical or behavioral conditions.
- ☐ Little to moderate support needs and requires significant support due to medical or behavioral conditions.
- ☐ Moderate-to-high support needs and requires more frequent supports that may include physical assistance in several daily life activities.
- ☐ Most significant support needs and requires frequent physical assistance in numerous daily life activities.
- ☐ Exceptional medical conditions and requires enhanced supports.
- ☐ Exceptional behavioral challenges and requires enhanced supports.

++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

## Part II: To be completed by the Legal Guardian or Responsible Party

I request and authorize the person providing care to myself or my family member, at my expense, to initiate emergency medical treatment through the designated physician or other recognized medical resource, including 911. When possible, the provider will contact the Legal Guardian or Responsible Party prior to such action unless there is a life-threatening emergency. I also agree to allow the provider to obtain emergency medical transportation at my expense.

I authorize the person providing care to release any and all medical information to the physician or treating facility.

_____ _____
**Responsible Party Signature** **Responsible Party Printed Name**

_____ _____
**Relationship** **Date**

_____ _____
**B&B Care Services Representative Signature** **Date**

# B&B Care Services, Inc.
# Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____Primary Contact Name:_____
Phone:_____Email:_____

## CONSENT FOR RELEASE/RECEIPT OF INFORMATION

Participant Name: _____

Address: _____

I hereby authorize B&B Care Services, Inc. to release and/or obtain any or all information needed to provide the supports and services requested including, but not limited to, health protected information.

**I understand that the purpose of this consent has been explained to my satisfaction and I understand its contents.**

(Initial Only One Response)

Yes_____ No_____
**Initial** **Initial**

This consent is valid for (1) year and I understand that I can withdraw this consent at any time except to the extent that action has been taken.

_____ _____
**Responsible Party Signature** **Responsible Party Printed Name**

_____ _____
**Relationship** **Date**

_____ _____
**B&B Care Services Representative Signature** **Date**

# Affidavit of Lawful Presence in the United States
## For Individuals 18 years of age or older

State of Georgia;
County of _____

Personally appeared before the undersigned office, duly authorized by law to administer oaths in the State of Georgia,_____(Applicant's name), who after being duly sworn, deposes and states from his/her own personal knowledge as follows:

I hereby do swear and affirm that I am:

(CHECK ONE BOX below as applicable)

☐ a United States citizen or legal permanent resident 18 years of age or older,

OR

☐ a qualified alien or non-immigrant under the federal Immigration and Nationality Act lawfully present in the United States, and I am 18 years of age or older.

Further affiant sayeth naught.

_____
Signature

_____
Printed Name

Sworn to and subscribed before me this____Day of_____, 20____.

_____
Notary Public Notary Seal:

My commission expires:
_____

| OFFICE USE ONLY: DD Professional – Review of Individual Family Support Plan | | |
|---|---|---|
| **Signature:** | **Name:** | **Date:** |

## 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 / EDWP
_____ 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? n/a

**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

# 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: B&B Care Services

Provider/Agency Address

Street Address: P.O. Box 1040

Street Address:

City, State, Zip: Springfield, Ga. 31329

Provider/Agency Phone Number: (912) 754-0817

Provider/Agency Fax Number: (866) 481-2097

## 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