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

PO Box 1040·Springfield, GA 31329·912-754-0817

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

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

For Office Use Only	
Effective Date: ________________	Expiration Date: _______________
Region: ________	Program: ________

Applicant Name: ____ Gender: ____________

Date of Birth: _____________ SSN: __________________ Medicaid Number: ______________________

Address: ____ City: _______________ State: ______

Zip Code: _______ County: _______________ Self Guardian: ______ Legal Guardian: _________________
(Proof of Guardianship required if age 18+)

Phone Number: *(primary)* __________________ Email: ____

Primary Qualifying Diagnosis: _____________________________________ Age at Diagnosis: __________

Other Diagnoses: ____

Allergies: ____

Emergency Contacts:

Contact Name	Contact Number	Contact Name	Contact Number
1.		3.	
2.		4.	

Race/Ethnicity:

☐ African American or Black
☐ American Indian or Alaska Native
☐ Other: _______________
☐ Hispanic or Latino
☐ White (non-Hispanic)
☐ Pacific Islander or Asian
☐ Multi-Racial

Eligibility Criteria:

☐ Intellectual/Developmental
☐ Desire to continue in Family Home
☐ Autism
☐ Currently Residing in a Family Unit

Other individuals living in your home (excluding applicant):

Name	Birthdate	Relationship to Applicant	Employed?		Disability *(if applicable)*
			☐ FT	☐ PT	
			☐ FT	☐ PT	
			☐ FT	☐ PT	
			☐ FT	☐ PT	
			☐ FT	☐ PT	
			☐ FT	☐ PT	

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Education:

Name of school applicant attends: ____ Grade: ____________

☐ Self-Contained ☐ Inclusion ☐ General Education ☐ 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:

Likes:	
Dislikes:	
Roles:	
Skills:	
Interests:	
Other:	

Describe what the individual feels is important in life:

Hobbies:	
Activities:	
Friends/Family:	
Other:	

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

Health:	
Education:	
Independence:	
Support Systems:	
Other:	

Individual's physical/sensory barriers, behaviors, or triggers accessing the community:

Barriers:	
Behaviors:	
Triggers:	

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Describe your family's current situation:

Physical Environment:	
Neighborhood:	
Other:	

Residence:

- ☐ Single Family Residence
- ☐ Townhome/Apartment
- ☐ Mobile Home
- ☐ Rent
- ☐ Own/Purchasing

Bedrooms: ______ Bathrooms: ______ Levels: ______ Fenced Yard? ☐ Yes ☐ No

Support Network:

- ☐ Family
- ☐ Friends
- ☐ Church
- ☐ Social Group
- ☐ Coworkers
- ☐ Support Group
- ☐ Other: ____

Current Services:

- ☐ DBHDD Planning List
  Navigator: ________________
- ☐ Private Therapies:
  ____
- ☐ Deeming Waiver (Katie Beckett)
- ☐ DBHDD State Funded Services
- ☐ SSDI/Survivors Benefits/SSI
  $_____ per month
- ☐ Food Stamps
  $_____ per month
- ☐ Adoption Assistance
- ☐ Medicaid
- ☐ ICWP
- ☐ Other: __________
  ____
- ☐ GAPP
  Hours per month: _____
- ☐ Child Care Assistance (CAP)
- ☐ Individual Education Plan
- ☐ Vocational Rehabilitation
- ☐ Easter Seals CHAMPIONS
- ☐ EDWP (CCSP/SOURCE)

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

If yes, why? ____

Unmet Needs of the Individual:

Unmet Need	Monthly/Annual Cost	Justification of Need

Additional Expenses for the Individual:

Additional Expense	Monthly/Annual Cost	Justification of Need

B&B Care Services, Inc.
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Family Support Budget Request

The following is a list of goods and services that qualify for Family Support funds subject to available funding.

Please complete requested amount for services and goods being requested.

Authorized Goods and Services	Specifics	Requested Amount	Prioritize *(Office Use Only)*	Authorized Amount *(Office Use Only)*	Measurable Goals *(Office Use Only)*
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.					
Community Living Support- An array of services to assist an individual with the developmental disability to perform activities of daily living.					
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.					
Supported Employment- Services to support individual to become gainfully employed and to maintain their employment in the community.					
Dental- 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- 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- 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.					

By signing/typing my name or initial, I verify that I am in agreement with and approve the information.

RESPONSIBLE PARTY INITIAL: _________

APPLICANT NAME: ______________________________

B&B Care Services, Inc.
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Authorized Goods and Services	Specifics	Requested Amount	Prioritize *(Office Use Only)*	Authorized Amount *(Office Use Only)*	Measurable Goals *(Office Use Only)*
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.					
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.					
Specialized Equipment- Adaptive and therapeutic devices specifically prescribed to meet the facilitative needs of the individual with a developmental disability or devices and equipment nee					
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.					

By signing/typing my name or initial, I verify that I am in agreement with and approve the information.

RESPONSIBLE PARTY INITIAL: _________

APPLICANT NAME: ____________________________

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Authorized Goods and Services	Specifics	Requested Amount	Prioritize *(Office Use Only)*	Authorized Amount *(Office Use Only)*	Measurable Goals *(Office Use Only)*
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- If a service or item does not fit the categories list, the provider submits a request for Other 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.					

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

If yes, by which sources? ____

By signing/typing my name or initial, I verify that I am in agreement with and approve the information.

RESPONSIBLE PARTY INITIAL: _________

APPLICANT NAME: ____________________________

B&B Care Services, Inc.
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Functional Assessment

Scale: *Use scale below to rate*
I = Independent
S = Needs Supervision (Cues, Coaxing, Prompting)
T = Total Assistance (Performs less than 25% of tasks)
N/A = Not Applicable

Area	Please Provide Description	Scale
Self-Care	(Ex: Feeding, Grooming, Bathing, Dressing, Toileting, Bladder/Bowel Management, etc.)	☐ I ☐ S ☐ T ☐ N/A
Mobility/Locomotion	(Ex: Assistance with transfers, use of wheelchair, crutches, walkers, etc.)	☐ I ☐ S ☐ T ☐ N/A
Communication	(Ex: Comprehension, Verbal Expressions, Non-verbal Expressions, Speech, etc.)	☐ I ☐ S ☐ T ☐ N/A
Psychosocial	(Ex: Social Interaction, Emotional Status, Adjustment to limitations, Employability, etc.)	☐ I ☐ S ☐ T ☐ N/A
Cognitive Functioning	(Ex: Problem Solving, Memory, Safety Judgement, etc.)	☐ I ☐ S ☐ T ☐ N/A
Medical/Physical	(Ex: Therapy Services (Occupational, Physical, Speech), Medications, Seizure Management, Colostomy Care, etc.)	☐ I ☐ S ☐ T ☐ N/A
Behavioral	(Ex: Assaultive, Self-Injurious, Behavioral Outbursts, Wandering, etc.)	☐ I ☐ S ☐ T ☐ N/A
Legal	(Ex: Criminal Charges, Legal Interaction, Incarceration, etc.)	☐ I ☐ S ☐ T ☐ N/A
Aging	(Ex: Dementia, Alzheimer's, Life Planning, etc.)	☐ I ☐ S ☐ T ☐ N/A
Co-Occurring	(Ex: Mental Health Diagnosis or Addiction Diagnosis)	☐ I ☐ S ☐ T ☐ N/A

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By signing/typing my name or initial, I verify that I am in agreement with and approve the information.

RESPONSIBLE PARTY INITIAL: _________

APPLICANT NAME: ______________________________

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

Please Initial:

______ I understand in consideration of my being allowed to participant in the program I must obtain prior approval 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 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 participant 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 Family Support is a non-entitlement program and 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 the Family Support annual maximum allowance is **UP TO** $3,000.00 per fiscal year and Respite services **UP TO** $4,900.00 per fiscal year.

______ 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 an emergency.

______ 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.

Responsible Party Signature	**Responsible Party Printed Name**
Relationship	**Date**
B&B Care Services Representative Signature	**Date**

OFFICE USE ONLY: DD Professional - Review of Individualized Family Support Plan		
DDP Name	**DDP Signature**	**Date**

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By signing/typing my name or initial, I verify that I am in agreement with and approve the information.

RESPONSIBLE PARTY INITIAL: _________

APPLICANT NAME: ___________________________

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 _______ Asian or Pacific Islander
_______ African American _______ Caucasian/Anglo
_______ Multi-Racial/Ethnic Group _______ 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 _____ Neurological Impairment (Prior to age 22)
_____ Intellectual Disability _____ Developmental Delay (0 – 8)
_____ Cerebral Palsy _____ Traumatic Brain Injury (Prior to age 22)
_____ Muscular Dystrophy _____ 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 _____ Social Security Disability Determination (SS)
_____ School IEP _____ Medical Verification
_____ Psychological Evaluation _____ 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

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

Street Address:

Check if Same as Individual

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