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

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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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.					

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RESPONSIBLE PARTY INITIAL: _________

APPLICANT NAME: ______________________________

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Individualized Family Support Plan

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.					

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RESPONSIBLE PARTY INITIAL: _________

APPLICANT NAME: ____________________________

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Individualized Family Support Plan

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? ____

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Individualized Family Support Plan

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

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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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**