FAMILY SUPPORT SERVICES

1503 N. Tibbs Rd
Dalton, GA 30720
(706) 270-5050

6 Mathis Dr NW
Rome, GA 30165
(706) 295-6425
Fax (706) 295-6478

To Whom It May Concern,

Thank you for your interest in our Family Support Services. I have enclosed the Family Support Services Application packet. Please complete these 4 forms and mail, email, fax or scan, and send them back along with the supporting documentation, such as an IEP, psychological or other evaluation. Once determined eligible, his/her name will be added to our waiting list until funds are available.

Please feel free to contact me by phone at (706) 295-6425 or by email – lisadodd@highlandrivers.org. If I am not available, you may call MaryAlice Jenkins, ext. 2069 or Hope Crabtree, ext. 2068.

Sincerely,

Lisa Dodd

Lisa Dodd
Family Support Supervisor

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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 (Optional):
_______ American Indian or Alaskan Native
_______ African American
_______ Multi-Racial/Ethnic Group
_______ Asian or Pacific Islander
_______ Caucasian/Anglo
_______ Other: ______________

Ethnicity (Optional): _______ Not Hispanic _______ Hispanic or Latino

Insurance Information:
Private: ________________ Public (Medicaid) #: ________________
Family member/Guardian Name: ____________________________________
Relationship to the Individual: ____________________________________
Legal Guardian of the Individual (Parent of a Minor Child/Guardian of an Adult Individual):
Home 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
_ 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

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 funded:

____
____
____
____

Section V: Agreement Section

I understand to be eligible for the Family Support Program the individual/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.

X______________________________ Individual's Signature (If over 18 years of age)

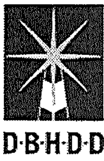
______________________________ Date

______________________________ Individual's Printed Name

______________________________ Parent/Legal Guardian's Signature (If under the age of 18)

______________________________ Date

______________________________ Parent/Guardian's 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/ APPLICANT INFORMATION

Individual Name: ____________

Individual Date of Birth: ____________

Individual Social Security Number: ____________

Individual Address: ____________

Street Address: ____________

Street Address: ____________

City, State, Zip: ____________

Individual Phone Number: ____________

Name of Family Member: ____________
(Person Applying on behalf of Individual)

Relationship to Individual: ____________

Family Member's Address: ____________

Street Address: ____________

Street Address: ____________

City, State, Zip: ____________

Check if Same as Individual ☐

Family Member's Phone Number: ____________

Check if Same as Individual ☐

PROVIDER INFORMATION

Provider/ Agency Name: Highland Rivers CSB

Provider/Agency Address: ____________

Street Address: ____________

Street Address: 6 Mathis Dr NW

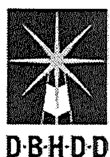
City, State, Zip: Rome, GA 30165

Provider/Agency Phone Number: (706) 295-6425

Provider/Agency Fax Number: (706) 295-6478

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 funding for such services/goods and is based on the availability of the Provider Agencies funding for Family Support Services.
________	Understands 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.
________	Understands and acknowledges 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.
________	Understands and attests 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/orreimbursement.
________	Understands and acknowledges that Family Support funds cannot be advanced, unless with express prior approval, to the Individual, to the Individual's Family, 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 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 receive <u>prior</u> approval 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.

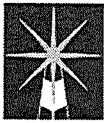
_____________ Understands and acknowledges that if the provider/agency determines that the annual funding amount will not be exhausted before end date of the Individualized Family Support Plan, the provider/agency has the right to reduce and/or remove funds without prior notification.

_____________ Understands and acknowledges that recipients of Family Support Services program, as a non-entitlement program and are not eligible to file appeals for services/goods, and or changes to funding.

_____________ 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 and cannot change agencies based on funding limitsonly. Transfers during the fiscal year must be reviewed and approved by the Regional Field Office.

_____________ 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.



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Family Support Services Agreements:

The Provider agrees as follows:

1. Provider will develop an Individual Family Support Plan (IFSP) for the Individual/ Applicant. Provider will develop the IFSP in consultation with Individual/ Applicant.
2. Provider will designate a Family Support Coordinator as a single point of contact to work with Individual/Applicant 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/ Applicant and 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 DBHDD review as requested.
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 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.

X ______________________________ ______________________

Individual/Applicant Signature Print Date

X ______________________________ ______________________

Family Member Signature Print Date

______________________________ ______________________

Family Support Coordinator Signature Date

RELEASE OF INFORMATION

Highland Rivers Community Service Board

FILL OUT EACH SECTION WHERE INDICATED	Individual's Name:

Section A – Authorization: [READ]

By signing this form, I authorize Highland Rivers, including any affiliated program, to use and disclose my individually-identifiable health information as specified below:

Section B – Authorized Recipients: [FILL-IN]

My information may be disclosed to / from: ______________________

Address:

Section C: Designation of records to be released [CHECK ALL THAT APPLY]

- ☐ Psychiatric/Psychological Records (evaluation, assessment, treatment, attendance and discharge plan)
- ☐ Clinic & Doctor Notes
- ☐ Group Notes
- ☐ Substance Use Disorder Treatment Records (assessment, treatment, attendance and discharge plan)
- ☐ Progress Notes
- ☐ Drug Screens
- ☐ Individual Service Recovery Plan
- ☐ Rehabilitation Plan
- ☐ Test/Lab Results
- ☒ Other: [specify] Case Coordination
- ☐ **HIV/AIDS**
- ☐ Individual Education Support Plan/Family
- ☐ Prescribed Medications

Section D: Purpose of Disclosure [MUST CHECK AT LEAST ONE]

- ☑ Continuity of care
- ☐ Determination of benefits
- ☐ Compliance with services and treatment plan
- ☑ Coordination of services
- ☐ Determination of eligibility
- ☐ Compliance with court ordered treatment plan
- ☐ Adherence to subpoena(s)
- ☐ Representation of Individual
- ☐ Treatment outcome and effectiveness
- ☐ If information is **not** substance use related and individual declines to state purpose check here.
- ☐ Other:

If request is for a specific time period or program please specify:

Date From: To: Program:

Section E: Expiration

I understand that this authorization will expire within one year of the date of my signature below unless I specify another date/event here: DISCHARGE

Section F: Other Information

I understand that: (1) the Highland Rivers CSB cannot guarantee that the recipient of this information will not re-disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about an individual in a substance use program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the individual or as otherwise permitted by federal law governing confidentiality of substance use rehabilitation patient records (42 CFR, Part 2); (2) except where I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the Highland Rivers CSB; and (3) I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Highland Rivers CSB in reliance on this authorization before written notice of revocation is received (See Notice of Privacy Practices).

X **Signature of Individual** ______________________ Date __________ Time ______ AM/PM

Individual's Date of Birth: __________ Last 4 digits of Individual's Social Security Number: _______

*

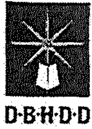
X ______________________ __________ ______ AM/PM

Signature of Parent or Legal Representative (if applicable) Date Time

***Must Specify Relationship to Individual (Parent, Guardian, etc.)**

USE THIS SPACE ONLY IF INDIVIDUAL WITHDRAWS CONSENT

Date revoked by Individual: __________ Signature of Individual ______________________



Georgia Department of Behavioral Health & Developmental Disabilities

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Name of Individual/Consumer/Patient/Applicant

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: GA Dept. of Behavioral Health and Developmental Disabilities 678-947-2818
(Name of health care provider holding the information - releasing agency)
1230 Bald Ridge Marina Rd Suite 800, Cumming GA 30041 Fax 678-947-2817
(Address) (Phone/Fax)

To: Highland Rivers
(Name of Person or Agency to whom information should be given - requesting agency)
6 Mathis Dr NW, Rome GA 30165
(Address) (Phone/Fax)

X ____ Initials — I authorize the following information from my records (and any specific portion thereof):
Eligibility documents

X ____ Initials — I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and I **BOTH** must initial here in order for this information to be released.

X ____ Initials — I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

The above disclosure of information is for the purpose of:
State Funded Family Support Services and/or
Medicaid NOW COMP Waiver Eligibility and Processes

1. *I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*
3. *I understand that DBHDD or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)*
   ☒ one (1) year OR ☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.

Signature of Individual/Consumer/Patient/Applicant | **Print Name** | **Date** | **Time am/pm**

OR Signature of other person authorized to sign for Individual(check one): | **Print Name** | **Date** | **Time am/pm**
☐ **Parent** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor**
☐ **Agent designated by Individual's advance directive**