Advantage Behavioral Health Systems
IDD Family Support Program

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
_____ Asian or Pacific Islander
_____ African American
_____ Caucasian/Anglo
_____ Multi-Racial/Ethnic Group
_____ Other: _____

Ethnicity (optional)
_____ Hispanic or Latino
_____ Not Hispanic

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
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
- ☐ 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.

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	

Return completed application to: ABHSFamilySupadvantagebhs.org

Or

IDD Family Support Program

Mail To: 250 Bray Street

Athens, GA 30601

Individualized Family Support Application

For Agency/Provider Office Use Only

Section VI: Eligibility Review and Determination

Individual's Name: _____

Date Completed Application Received: _____

Disposition for Family Support:

☐ Eligible For Family Support Services (Forward Application and Supporting Documents to the Regional RSA)

☐ Ineligible For Family Support Services

Provider Agency - Name: _____

Provider Staff - Name: _____

Title: _____ Contact Number: _____

E-Mail Address: _____

Provider Staff - Signature: _____ Date: _____

Section VI:

For Regional Office Use Only

Date Application Received
Date Application Reviewed: _____

Disposition for Family Support:

☐ Yes Eligible Status Verified:

☐ No - State the reason:

_____

_____

Provider: _____

Date of Notification: _____

Regional Staff's Name: _____ Title: _____

Regional Staff's Signature: _____ Date: _____