TN Department of Intellectual & Developmental Disabilities | Family Support Program

# Family Support Intake Form

## THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Date:_____ County of Residence: _____

**Name of person with severe/developmental disability that Family Support is being applied for:** _____

Social Security #:_____-_____-_____ Date of Birth:_____/_____/_____Age: _____

**Name of Parent/Spouse/Legal Representative, if different than above:** _____

Family's Address:_____ E-mail: _____

_____ Phone:_____Phone: _____

**Potential Support Services Needed/Requested (Check all that apply):**

- ☐ Before/After Care
- ☐ Behavior Services
- ☐ Daycare
- ☐ Emergency Living Expenses
- ☐ Family Counseling
- ☐ Health Related
- ☐ Homemaker Services
- ☐ Home Modifications
- ☐ Nursing/Nurse's Aide
- ☐ Personal Assistance
- ☐ Recreation/Summer Camp
- ☐ Respite
- ☐ Specialized Equipment & Maintenance/Repair
- ☐ Specialized Nutrition/ Clothing/Supplies
- ☐ Training
- ☐ Transportation
- ☐ Vehicle Modifications
- ☐ Other _____

**Do you (the person applying for Family Support) receive any of the following? (Check all that apply):**

- ☐ Adoption Assistance
- ☐ Food Stamps
- ☐ Residential Services
- ☐ Social Security Income
- ☐ Social Security Disability Income
- ☐ Foster Care
- ☐ OPTIONS Program
- ☐ Tennessee Early Intervention System(TEIS)
- ☐ PACE (Program of All-Inclusive Care for the Elderly)
- ☐ MAPs (Medicaid Alternative Pathway to Independence)
- ☐ Vocational Rehabilitation
- ☐ Nursing Services
- ☐ Supported Living
- ☐ None

**What type of insurance do you (the person applying for Family Support) have?**

☐ TennCare (Medicaid) ☐ Medicare ☐ Private Insurance ☐ Uninsured

**Have you (the person applying for Family Support) applied for or do you receive any of the following? (Check all that apply):**

☐ CHOICES ☐ ECF Choices ☐ DIDD Waivers ☐ Katie Beckett Program ☐ Any in home or community supports ☐ None

**To comply with Title VI, the following information is being requested:**

**1. RACE (Check all that apply)** [federal standards consider "Hispanic/Latino" to be an Ethnicity, to be answered below, separate from "Race"]:

☐ American Indian/Alaskan Native ☐ African American/Black ☐ Caucasian/White ☐ Hawaiian/Other Pacific Islander ☐ Asian ☐ Other

**2. ETHNICITY** [if self-identified as "Hispanic/Latino," please answer the Race question separately above and then "Hispanic/Latino" here]:

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

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**Primary Disability** – Check which of the following "major disability categories" is most relevant to the person services are being requested for (as a primary diagnosis):

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Blind
- ☐ Deaf
- ☐ Health Impairment
- ☐ Traumatic Brain Injury
- ☐ Other _____
- ☐ Intellectual Disability
- ☐ Neurological Impairment
- ☐ Orthopedic Impairment/ Physical Disability
- ☐ Spinal Cord Injury
- ☐ Developmental Delay
- ☐ Down syndrome
- ☐ Genetic Disorders: (ex. Rett, Angelman, Trisomy 9, etc.) Please specify_____

**Did the person's primary disability occur:** ☐ Prior to age 22 ☐ At age 22 or after

**NOTES: Please explain in detail how the Family Support funds would assist your family. Based on the diagnosis of the applicant, what needs is he/she unable to obtain without these supports? How would the applicant's daily life be improved with this assistance? Use additional paper if necessary.**

_____

_____

_____

_____

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**By signing and dating this Intake Form I, the person applying or their legal representative, indicate that all the information above is true and accurate. Furthermore, I understand that providing invalid, inaccurate, or Incomplete information could be considered as fraud and may result in a criminal investigation and disqualification from the program which would prevent re-application in subsequent years.**

_____

**Signature of Person Applying or Legal Representative** **Date**

How was this information obtained (i.e., face to face visit, by phone or mail)?

_____

**If someone other than the family/applicant is making a referral:**

Name of person making referral to Family Support: _____

Agency:_____ Phone:_____

Address: _____

CLAIMS AND REPORTING PROCESS USER'S GUIDE can be found on the DIDD Internet.

***General Definitions***

The following definitions provide clarification on the scope of frequently used Family Support services.

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| **Before/After Care** | Before/after care is a form of day care provided to either children or adults. It is provided either before or after school or a day activity. Its typical purpose is to enable the caregiver to work. |
| **Behavior Services** | Behavior Services includes the assessment or analysis of behavior that presents a health or safety risk to the person or others or that significantly interferes with home or community activities, assessment of the settings in which such behaviors occur and the events which precipitate the behaviors; the development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of the caregivers. Behavior Services must be provided by a credentialed professional. |
| **Day Care** | Day care is a service that typically provides out of home care for a child or adult on a regular ongoing basis. Generally, day care is provided to enable a caregiver to engage in a regularly scheduled activity such as employment. Day care services may or may not be provided in a licensed program. |
| **Emergency Living Expenses** | Housing Costs may cover the establishment of a home or emergency housing expenses that are necessary to prevent the loss of the home or to protect the health, safety, or welfare of the person with a disability (for example, utilities, propane, or insurance premiums (seek public assistance first). but should not cover ongoing expenses such as mortgage, rent, or utility expenses. |
| **Family Counseling** | Counseling provided to the person or caregiver related to challenges in the life of the person with a disability. |
| **Health Related** | Health related include services provided by a licensed health provider and may include, but are not limited to, medicine, dentist visits, dentures, medical bills, therapy, respiratory, vision, hearing. Health Related may also cover the cost of non-prescription items such as over the counter medications, first aid supplies and other items needed for the health or welfare of the person with a disability. While Family Support funding may be utilized to purchase medication, a recipient of Family Support funding must ensure all prescription medication purchases are appropriate and utilized in accordance with the prescribing physician and in line with standard medical practice. Any evidence of misappropriation of Family Support funds for narcotics or other drugs of abuse and/or "doctor shopping" will be reported to state law enforcement officials for appropriate action under state and federal laws. Moreover, any payments for Family Support funding |

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| | related to abuse of drugs may be withheld pending confirmation of appropriate medical use. |
| **Home Modifications** | Home modifications include interior or exterior physical modifications to a person's place of residence that are needed to ensure the health, welfare, and safety of the person or to enable the person to function with greater independence. Examples include, but are not limited to:, wheelchair ramps, widening of doorways, modifications of bathroom and kitchen facilities, and installation of specialized electrical or plumbing system to accommodate necessary medical equipment and supplies. |
| **Homemaker Services** | These services are provided to the whole family or household. Homemaker services include general household activities and chores such as sweeping, mopping, dusting, changing linens, making beds, washing dishes, doing personal laundry, ironing, mending, meal preparation, and assistance with maintenance of a safe environment. Family members may be paid to provide homemaker services but cannot be the spouse, the parent or guardian/conservator of a minor child or an adult, or another family member living in the same residence as the person receiving the homemaker services. Exceptions to these provisions may be made at the discretion of the Local Council. |
| **Nursing/Nurses Aid** | Nursing includes services provided by registered nurses, licensed practical nurses, or nurse's aides that are ordered by the person's physician, physician assistant or nurse practitioner. These services may be provided in home and community settings but may not be provided in in patient hospitals. |
| **Personal Assistance** | Personal assistance provides in-home or community support to a person with a disability. Services may include, but are not limited to, assistance with activities of daily living (for example, bathing, dressing, personal hygiene, eating), related household activities or chores (for example, meal preparation, washing dishes, personal laundry, general housecleaning), and budget management. Personal assistance may also be provided in the community but is not intended to replace services covered by schools or other programs. Community-based services may include, but are not limited to, accompanying the enrollee on personal errands such as grocery shopping, picking up prescriptions, paying bills; trips to the post office, and medical appointments as well as assisting the person with interpersonal and social skills building in community settings. Family members may be paid to provide personal assistance but cannot be the spouse, the parent or guardian/conservator of an adult or minor child, or another family member living in the same residence as the person receiving the personal assistance. Exceptions to these provisions may be made at the discretion of the Local Council. |
| **Recreation/** | Recreation/summer camp may include, but is not limited to, the cost |

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| **Summer Camp** | of attendance at camp for either a child or adult with disabilities, therapeutic activities, horse therapy, swimming, YMCA activities, and participation in other community recreational activities. |
| **Respite** | Respite is a service that provides a break from caregiving responsibilities. Respite may be short or long term and may take place at home or somewhere else. Respite may be a service that is planned in advance or may be also provided in emergency circumstances. The services that have sometimes been called sitter should be included in this category. Family members may be paid to provide respite but cannot be the spouse, the parent or guardian/conservator of a minor child or an adult, or another family member living in the same residence as the person receiving the respite. Exceptions to these provisions may be made at the discretion of the Local Council. |
| **Specialized Equipment & Repair/Maintenance** | Specialized equipment and repair/maintenance means assistive devices, adaptive aids, controls, or appliances which enable a person to perform activities of daily living or to perceive, control or communicate with the environment. The service also includes accessories and supplies for the equipment as well as repairs or maintenance for the proper functioning of such items. Examples include, but are not limited to communication devices, hearing devices, personal emergency response systems, specialized lifts, positioning equipment, wheelchairs, seating devices, assistive technology, and software. |
| **Specialized Nutrition/ Clothing/Supplies** | Specialized nutrition may include services performed by a Nutritionist/Dietician and food items such as ensure, boost, gluten free products, and other dietary products necessary for the health and well-being of persons with disabilities.<br><br>Specialized clothing may be necessary for individuals who, due to their disability, need larger or smaller clothes than generally available, need clothing with more reinforcement than generally available, need clothing with fasteners other than what is generally available, etc.<br><br>Supplies are to benefit the person with a disability whose needs go beyond those of the general population for cleanliness, warmth, cooling, etc. |
| **Training** | Training may include services provided directly to the person with a disability or to the person's caregiver and may include, but is not limited to, conference costs, lodging costs, educational activities, and consumer training. |
| **Transportation** | Transportation includes the cost of directly transporting a person with a disability to day services, his or her job, medical or non-medical appointments, or various related activities. Transportation may also include the cost of a bus ticket, taxis, or other types of transportation used to enable the person to participate in nearby |

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| | community activities. Transportation may include vehicle repairs or an emergency car insurance premium.<br><br>Long distance travel includes the cost of mileage, meals for the recipient, and/or lodging associated with transporting the recipient.<br><br>A transportation form is in Appendix C of the Family Support Guidelines and must be completed to invoice for this service. |
| **Vehicular Modifications** | Vehicular modifications include interior or exterior physical modifications to a vehicle owned by a person with a disability or by the primary caregiver of a person with a disability and which is routinely available for transporting the person with a disability. Examples include but are not limited to: lifts that allow access to the vehicle, interior modifications such as grab bars, head/leg rests, devices to secure wheelchairs in a stationary position, roof modifications, safety belts, steering control adaptations, changes to car pedals, and remote switches. |

Department of Intellectual & Developmental Disabilities | Family Support Program

# CITIZENSHIP ATTESTATION FORM

Date: _____ Family Support Provider Agency: _____

Name of Family Support Recipient: _____

Address of Family Support Recipient: _____

_____

_____

Phone Number of Family Support Recipient: _____

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*Please complete the section below and check the appropriate status*.

I, _____ (*name of Family Support recipient*), hereby attest that I am (*please check one box*)

[ ] **a United States citizen** or

[ ] **a qualified alien**.

I understand that if I do not provide the appropriate documentation necessary to verify my citizenship or qualified alien status, then I will not be eligible to receive Family Support benefits. Also, I understand that if I knowingly and willfully make a false, fictitious, or fraudulent statement or representation of citizenship or qualified alien status, I may be found to be liable under the False Claims Act in T.C.A. § 4-18-101 et seq., criminal charges under 18 U.S.C. § 911, or any other applicable federal or state statute.

_____

**Signature of Family Support Recipient**

***If form is completed by someone other than the Family Support recipient:***

I, _____, hereby attest that the information provided in this form is true and accurate to the best of my knowledge. Furthermore, I was either given permission by the recipient or have the legal authority to complete and submit this form on his/her behalf.

_____ _____

**Relationship to FSP Recipient** **Signature** **Phone #**

**NOTE: Return this signed form to your Family Support provider agency. This form must be completed annually.**

TN Department of Intellectual & Developmental Disabilities | Family Support Program

**APPEALS/GRIEVANCE PROCEDURE**

**AND FRAUD, WASTE AND ABUSE POLICY**

## Appeals/Grievance Procedure

The following procedure shall be followed should a family become dissatisfied or have a dispute pertaining to program operations, staff, services provided, or decisions made. Every effort shall be made to settle the issue as quickly as possible and as close to the source as possible.

The complaint shall first be brought to the attention of the Family Support Coordinator at your local agency. The coordinator will attempt to remedy the situation to the satisfaction of all parties.

If attempts at resolution are unsuccessful at the agency level, the following procedure shall be followed to resolve any complaint or grievance regarding Family Support services:

1. *Local Council Review*-The family shall contact the DIDD Regional Office Family Support staff in writing or by phone to report the complaint or grievance. East, TN 423-787-6935, West, TN 901-355-1571, Middle, TN 615-231-5057. This notification shall occur within thirty days of the aggrieved occurrence. The Regional Office will forward the source of complaint or grievance in writing to the Local Council for resolution. The Local Council shall meet with the agency separately from the family, and shall offer to meet with the family separately, to discuss the complaint/grievance and present evidence. The agency is required to have a representative meet with the Local Council. It is the family's choice to either: (1) attend the meeting in person; (2) attend the meeting with an advocate; (3) send an advocate to the meeting on their behalf; or (4) have the Local Council rely solely on the documentation provided by the family. If the family does decide to have an advocate attend the meeting with the Local Council, the family will provide notice to the DIDD Regional Office Family Support staff at least 48 hours prior to the meeting. If this deadline is not met, then the meeting will be re-scheduled to a time where the 48-hour timeline for notice by the family can be met. The meeting of the Local Council with the agency may occur at a different date than the meeting of the Local Council with the family or the review of the documentation submitted by the family without their attendance. The meeting(s) of the Local Council shall occur as soon as possible following the receipt of the written complaint/grievance. Within ten business days following both: (1) the meeting of the Local Council with the agency, and (2) either the meeting of the Local Council with the family or a review of the documentation submitted by the family without their attendance; the Local Council shall compile a meeting summary and submit it along with its decision to the DIDD Regional Office and Family Support staff as well as notify the family of its decision in writing.
2. *District Council Review* - If the family is not satisfied with the Local Council decision, the family shall contact the DIDD Regional Office Family Support staff in writing or by phone within ten business days following receipt of the notification from the Local Council of its decision. East, TN 423-787-6935, West, TN 901-355-1571, Middle, TN 615-231-5057. The Regional Office will forward the complaint or grievance in writing to the District Council for resolution. The District Council shall meet with the agency separately from the family, and shall offer to meet with the family separately, to discuss the complaint/grievance and present evidence. The agency is required to have a representative meet with the District Council. It is the family's choice to either: (1) attend the meeting in person; (2) attend the meeting with an advocate; (3) send an advocate to the meeting on their behalf; or (4) have the District Council rely solely on the documentation provided by the family. If the family does decide to have an advocate attend the meeting with the District Council, the family will provide notice to the DIDD Regional Office Family Support staff at least 48

hours prior to the meeting. If this deadline is not met, then the meeting will be re-scheduled to a time where the 48-hour timeline for notice by the family can be met. The meeting of the District Council with the agency may occur at a different date than the meeting of the District Council with the family or the review of the documentation submitted by the family without their attendance. The meeting(s) of the District Council shall occur as soon as possible following the receipt of the written complaint/grievance. Within ten business days following both: (1) the meeting of the District Council with the agency, and (2) either the meeting of the District Council with the family or the review of the documentation submitted by the family without their attendance; the District Council shall compile a meeting summary and submit it along with its decision to the DIDD Regional Office and Family Support staff as well as notify the family of its decision in writing.

3. *State Council Review* - If the family is not satisfied with the District Council decision the family shall contact the DIDD Regional Office Family Support staff in writing or by phone within ten business days upon notification from the District Council. East, TN 423-787-6935, West, TN 901-355-1571, Middle, TN 615-231-5057. The Regional Office staff will forward the source of the complaint or grievance in writing to the Chairperson of the Family Support State Council and to the State Coordinator of the Family Support Program. The Family Support State Council will review the complaint or grievance at its next scheduled meeting following the date of the decision of the District Council. While the agency is required to have a representative at the State Council meeting, it is the family's choice to either: (1) attend the meeting in person; (2) attend the meeting with an advocate; (3) send an advocate to the meeting on their behalf; or (4) have the State Council rely solely on the documentation provided by the family. The Regional Office Family Support staff will help the family compile a written form of findings for the Family Support State Council meeting. The State Council shall notify the family of its decision in writing within ten business days following the meeting. The decision of the Family Support State Council is final.

Fraud, Waste and Abuse Policy

The Family Support Program and its staff, provider agencies and volunteers shall comply with DIDD Policy 70.2.1 related to preventing, detecting, and reporting fraud, waste and abuse of government funding. Individuals enrolled in the Family Support Program (and/or his/her guardian/conservator) shall comply with DIDD Policy 70.2.1, as applicable. See appendix I.

It is expected that the provider agency, volunteers, service providers and the individual enrolled in the Family Support Program (or his/her guardian/conservator) shall cooperate with investigative matters. Failure to cooperate could result in denial of a claim, termination of the Family Support contract, disenrollment from the program and/or a criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.

By signing and dating this form, I, the person supported or legal representative, understand that I must abide by the procedures stated above and as applicable, incorporated in the Family Support Guidelines. Furthermore, I understand that providing invalid, inaccurate, or incomplete information may be considered as fraud, waste or abuse and may result in denial of a claim, disenrollment from the program and/or criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.

*A full copy of the Family Support Guidelines can be located at:

Family Support Guidelines

**Note:* A hard copy may be requested from the agency

*****A signed acknowledgement form must be maintained in the file*****

Department of Intellectual & Developmental Disabilities | Family Support Program

**20__-20__ ACKNOWLEDGMENT OF RECEIPT OF THE APPEALSGRIEVANCE PROCEDURE and FRAUD, WASTE AND ABUSE POLICY**

By signing and dating this form, I, the person supported, or legal representative indicate that I have received and understand the forms listed below:

☐ **Appeals/Grievance Procedure**

☐ **Fraud, Waste and Abuse Policy**

_____ _____

Signature of Individual Date Signed

or

_____ _____

Personal Representative/Guardian as applicable Date Signed

_____ _____

Signature of Agency Employee Date Signed