Family Support Application Checklist & Instructions:

Be sure to complete **ALL** areas of the application. If you are unsure what information to provide and need additional clarification please contact Karen Tharpe – Parent Mentor for the Appling County School System for additional assistance. **Incomplete applications will be returned to parents/guardians for completion before they can be sent to the provider for processing**.

_____Initial for acknowledgment.

Packet Contents: *Check off the items below once you have read and/or completed the information requested in the document.*

_____ (Pages 1-2) **Application Instructions and Checklist** – This checklist was designed locally to assist you with outlining the application process, forms, and documentation required to complete your request for Family Support Services.

_____ (Page 3) **Welcome Letter** – This is a welcome letter from the ACSS Parent Mentor (Karen Tharpe) which lists contact information to reach your school systems parent mentor.

_____ (Pages 4-5) **Quick Resource Links** – This page has information about website links where parents may find additional help information and other resources. It also has a resource for parents/guardians to stay connected and receive updates from the parent mentor through using "Remind" with the specific text code.

_____ (Pages 6-8) **ACSS Notice/Authorization to Release Information** – This page must be signed by the parent/guardian so the Parent Mentor can release/obtain information to submit the Family Support application.

_____ (Page 9) **Region 5 Field Office Information** – This page provides parents with information about and how to contact the Region 5 BHDD Field Office and has the contact info for G.C.A.L. (Georgia Crisis & Access Line).

_____ (Pages 10-11) **Family Support Services Information** – This page provides parents with information about the Family Support Services. It provides them with some information regarding: eligibility, services offered, details about applying for services, and a list of providers for the Appling County area. ***Parents need to check the box next to the provider agency they would like the Parent Mentor to submit their Family Support Application to for processing & potential services.***

_____ (Pages 12-16) **Family Support Services & Goods Funding Limits** – These pages provides parents with the DBHDD funding limits chart for Family Support Services & Goods. ***Parents should keep these pages to refer to for future service requests.***

_____ (Pages 17-24) **Family Support Application and Agreement** – This is the Family Support Application and Agreement that parents must complete to request services. **ALL** areas of the application and agreement must be completed before it can be sent to the selected provider for processing. The Parent Mentor for the school system will assist your family with providing a copy of the School IEP, School Eligibility, and Medical information on file that may support the Family Support application. Other copies of documentation may be requested by the Parent Mentor and/or Provider Agency that the parent/guardian would need to provide to complete the application request.

_____ (Pages 25-28) **Initial Assessment for Family Support** – This questionnaire will help give the provider details to assist with developing the individuals Family Support Plan for each fiscal year. It will also help determine his/her service categories and funding allotments.

Complete the following pages if you selected Pineland BHDD as the Family Support provider agency.

_____ (Pages 29-31) ***Pineland DBHDD FY_____ IFSP Annual Review** – If you selected Pineland DBHDD as your Family Support Provider of choice, then you will need to complete this form annually.

_____ (Page 32) ***Pineland DBHDD Family Support Goods & Services Request** – If you selected Pineland DBHDD as your Family Support Provider of choice, then you will need to **only sign** this form. This form will remain on file so when you call, email, or text your parent mentor or provider they can use this form to process your request.

_____ (Page 33) ***Pineland DBHDD Authorization for Release of Information (Standard Request)** – If you selected Pineland DBHDD as your Family Support Provider of choice, then you will need to **initial and sign** this form. This form will remain on file so when you call, email, or text your parent mentor or provider they can use this form to attach to your Goods & Services request for processing.

_____ (Pages 34-35) ***Pineland DBHDD Family Support Travel Expense Report** – If you selected Pineland DBHDD as your Family Support Provider of choice, then you will need to **only sign** this form. This form will remain on file so when you call, email, or text your parent mentor or provider they can use this form to complete your request for travel reimbursement. **You must provide a copy of the doctor's excuse or appointment card for the date of service, lodging receipts, meal receipts, and the start and ending vehicle odometer reading for the trip for your request to be processed.**

_____ (Pages 36-37) ***Pineland Community Services "Other Category Assistance Worksheet"** – If you selected Pineland DBHDD as your Family Support Provider of choice, then you will need to **only sign** this form. This form will remain on file so when you call, email, or text your parent mentor or provider they can use this form to complete your request for processing. This request would be used if a family is having a financial hardship and need financial assistance paying some bills (Non-Luxury Items). Example: Past due electric bill so the lights would not be cut off to the individual's home (only allowable once per fiscal year).

*Other providers may require similar forms be completed, but it will be given to you by that specific provider.

These are general details about the Georgia Family Support Services Program that were current at the time this packet was developed by the Parent Mentor of the Appling County School System. This is a state funded non-entitlement program and the local school system does not approve or deny applications for this program. The Parent Mentor for school system only assists parents/guardians with applying for funding support through the program and can assist the parents/guardians with submitting their Family Support requests to the provider for processing. The Parent Mentor/Appling County School System are not responsible for making sure the families follow the required guidelines for maintaining funding approval.

Thank you,

Karen Tharpe

Parent Mentor

Appling County Board of Education

Karen Tharpe,
Parent Mentor-SPED
Karen.Tharpe@appling.k12.ga.us
www.appling.k12.ga.us

249 Blackshear Highway
Baxley, Georgia 31513
Phone (912) 367-8600 Ext. 166
Fax (912) 367-1011
Cell (912)278-4736

Dear Parent/Guardian,

I wanted to take a moment to introduce myself to you and your family. My name is Karen Tharpe, and I have the pleasure of being your Parent Mentor. I have been employed with the Appling County School System since 2011 and have served as the Parent Mentor since 2015.

Who am I? I have lived, worked, and attended school in Appling County most of my life. In 2002 I married my wonderful husband Ed Tharpe, and we have two amazing children who both attend Appling County Public Schools. I strongly believe that every child is special and have unique gifts and talents regardless of their different abilities or special needs.

You may wonder what qualifies me to be your Parent Mentor: Well, just like you, I also have a child with special needs which is served with an IEP within our school system. I have firsthand knowledge of the challenges that face our special needs children in the classroom, in the community, and at home. I am here to support and to assist other parents by providing information and/or resources to help their children be more successful in school, at home, and in the community. I can assist parents just beginning the process of receiving Special Education Services for their child, as well as, the parent looking for information to help their graduating adult transition to life after school.

How can you reach me? My office is located at the Appling County Board of Education: 249 Blackshear Highway, Baxley, GA 31513. I work Monday through Friday during the regular academic school year. I serve all students/families receiving Special Education Services at all of our Public Schools in Appling County. You may contact me by phone, email, or mail to schedule an appointment for me to assist you with locating trainings, information, services, or other resources for your special needs child.

Our school system has an excellent Special Education Program and my goal is to work together with families in helping every child achieve their potential and succeed in reaching their life goals.

Sincerely,

Karen Tharpe
Parent Mentor - SPED

Quick Resource Links:

Appling County School System

http://www.appling.k12.ga.us

Georgia Parent Mentor Partnership

http://www.parentmentors.org

Georgia Department of Education

http://www.gadoe.org

Georgia Council for Developmental Disabilities

http://www.gcdd.org

Georgia Department of Community Health

https://dch.georgia.gov

Georgia Department of Behavioral Health & Developmental Disabilities

http://dbhdd.georgia.gov

United We Can

Would you like to receive emails or text messages from your Parent Mentor about upcoming events, trainings, important dates or information you may want to know? If so, below are some ways you may subscribe to receive these types of information.

Remind:

TEXT

Enter this number
81010

Text this message
@acsspmsped

Email:

Send your email address to karen.tharpe@appling.k12.ga.us to be added to my email distribution list.

Website:

www.appling.k12.ga.us

Please email or call me to let me know if you would like me to host some parent trainings or parent/student workshops. If so, what type of information or training area would you like more information about? (Ex: Autism, ADHD, Discipline, Medicaid, SSI, etc.). What times would work best for your schedule? (Mornings, Evenings, Weekends, etc)

Parent Mentor - Karen Tharpe / Office: (912)367-8600 Ext. 166 / Email: Karen.Tharpe@appling.k12.ga.us

Request made of parent by : ☑ SPED ☐ RtI ☐ 504 ☐ PIP ☐ Pre-K ☐ Other

Appling County School System

Notice/Authorization to Release Information

Student Name _____ Date of Birth _____

School _____ Grade _____

I hereby authorize my child's doctor/medical professional:

Doctor Name: _____

Address: _____

FAX Number: _____ Phone Number: _____

to release confidential records for the child named on this form to:

Appling County School System

Karen Tharpe - Parent Mentor SPED Dept.

Phone 912-367-8600 ext. 166

Fax 912-367-1011

COMMENTS:

Records to be Released:	**Reasons for Release:**
☑ Medical Documentation that indicates a current diagnosis (within 1 calendar year of today's date) of any kind of illness/disorder such as: ADD, ADHD, Seizures, OCD, Bipolar, etc.	☐ Educational planning purposes
☑ Medical Records	☑ Other: _____
☑ Psychological Evaluation/Assessment	

Please sign below that you understand and agree to the above statement.

Signature of Parent/Guardian: _____

Date: _____

***It is understood that the party to whom this information is released will not release it to a third party without appropriate consent.

Appling County Board of Education

Pam Thomas,
Special Education Director
Pam.Thomas@appling.k12.ga.us
Office Ext. 162

Karen Tharpe,
Parent Mentor-SPED
Karen.Tharpe@appling.k12.ga.us
Office Ext. 166

249 Blackshear Highway
Baxley, Georgia 31513
Office (912) 367-8600
Fax (912) 367-1011
www.appling.k12.ga.us

Authorization to Release Confidential Information/Coordination of Services

Student Information:

Student Name:_____ Date of Birth: _____

School: _____ Grade: _____

HR Teacher: _____ Medicaid # (If applicable):_____

(If applicable)
Coverage with ____ Amerigroup ____ CareSource ____ peach state health plan ____ WellCare

I hereby authorize the Appling County School System Employee listed below to assist with coordinating services, scheduling appointments, and receiving/releasing confidential information/records pertaining to my child at my request:

Name: Karen Tharpe Phone #: 912-367-8600 ext. 166

Title: Parent Mentor - SPED Email: Karen.Tharpe@appling.k12.ga.us

Address: 249 Blackshear Highway / Baxley, GA 31513 Fax #: 912-367-1011

I hereby authorize my child's doctor/medical professional/agency provider listed below to allow the ACSS Employee listed above to assist with coordinating services and receiving information regarding my child named on this form:

Name:_____ Phone #:_____

Address:_____ Fax #:_____

It is understood that the individual I've authorized to coordinate services for my child will only share the confidential information received with other ACSS staff /doctors /medical professionals /agency providers to help facilitate the coordination of educational/medical services/ and apply for additional resource assistance for my child. **My signature below acknowledges I understand and agree with the statements outlined in the above document.**

Signature of Parent/Guardian:_____Date:_____

Appling County Board of Education

Pam Thomas,
Special Education Director
Pam.Thomas@appling.k12.ga.us
Office Ext. 162

Karen Tharpe,
Parent Mentor-SPED
Karen.Tharpe@appling.k12.ga.us
Office Ext. 166

249 Blackshear Highway
Baxley, Georgia 31513
Office (912) 367-8600
Fax (912) 367-1011
www.appling.k12.ga.us

Authorization to Release Confidential Information/Coordination of Services

Student Information:

Student Name:_____ Date of Birth: _____

School: _____ Grade: _____

HR Teacher: _____ Medicaid # (If applicable):_____

(If applicable)
Coverage with ____ Amerigroup ____ CareSource ____ peach state health plan ____ WellCare

I hereby authorize the Appling County School System Employee listed below to assist with coordinating services, scheduling appointments, and receiving/releasing confidential information/records pertaining to my child at my request:

Name: Karen Tharpe Phone #: 912-367-8600 ext. 166

Title: Parent Mentor - SPED Email: Karen.Tharpe@appling.k12.ga.us

Address: 249 Blackshear Highway / Baxley, GA 31513 Fax #: 912-367-1011

I hereby authorize my child's doctor/medical professional/agency provider listed below to allow the ACSS Employee listed above to assist with coordinating services and receiving information regarding my child named on this form:

Name:_____ Phone #:_____

Address:_____ Fax #:_____

It is understood that the individual I've authorized to coordinate services for my child will only share the confidential information received with other ACSS staff /doctors /medical professionals /agency providers to help facilitate the coordination of educational/medical services/ and apply for additional resource assistance for my child. **My signature below acknowledges I understand and agree with the statements outlined in the above document.**

Signature of Parent/Guardian:_____ Date:_____

Field Offices

The DBHDD system of services is administered through six **Field Offices.** These offices administer the hospital and community resources assigned to the region. The regional field offices:

- Oversee statewide initiatives.
- Develop new services and expand existing services as needed.
- Monitor the services being received by consumers to ensure quality and access.
- Investigate and resolve complaints.
- Conduct special investigations and reviews when warranted.

Region 5 Field Office

For emergency mental health, developmental disability or addictive disease services, call:
Georgia Crisis & Access Line: 1-800-715-4225
For non-emergency developmental disability services, call:
Intake & Evaluation Team
Phone: 912-303-1649
Fax: 912-351-6309

Jose Lopez, Behavioral Health Regional Services Administrator
Michelle Brubaker, Developmental Disabilities Regional Services Administrator
1915 Eisenhower Drive, Building 7
Savannah, GA 31406
Phone: (912) 303-1670
Fax: (912) 303-1681

Family Support Services

Family Support Services is a non-entitlement program which brokers disability specific services based on each individual and families unique needs. Family Support Services are based on the value that families belong together and individuals are best served in the community setting. These supports meet every day needs that are often critical in avoiding family crises. The goal of Family Support Services is to assist in maintaining a cohesive family unit and to assist the individual to live at home in the community.

Eligibility

Individuals, age 3 and up, living in Georgia that have been diagnosed with a developmental disability who are living at home, with their family, and are not currently receiving a NOW/COMP Waiver, are eligible for Family Support Services.

Eligible diagnoses include, but are not limited to:

- Developmental Disability
- Intellectual Disability
- Cerebral Palsy
- Autism Spectrum Disorders
- Down Syndrome

Services

Family Support Services brokers services and goods that are individualized to meet your family's needs. A Family Support Coordinator will work with your family to develop an Individualized Family Support Service Plan. Some of the services might include:

- Information and referral.
- Assistance in identifying needs.
- Advocacy to obtain needed services or benefits.
- Assistance locating and acquiring services such as:
- Respite Services
- Family Education
- Special diets, clothing, and personal care items
- Other services and supports unique to each family's needs

Apply for Services

1. Families must complete an **Application** **(Provided in this packet or printed online at https://dbhdd.georgia.gov/family-support-services)**
2. Complete the **Family Support Agreement** **(Provided in this packet or printed online at https://dbhdd.georgia.gov/family-support-services)**

3. Provide supporting documentation of the identified developmental disability. Supporting documentation includes documents that indicate the individual has been diagnosed with a developmental disability, including:
   - DD Intake and Evaluation Assessment through a DBHDD Regional Office
   - Psychological Evaluation
   - School IEP
   - Medical Verification of ID/DD by a Physician
   - Social Security Disability

   Family Support Services applications are accepted at the local community based providers or through contact with your Parent Mentor for the school system.

Family Support Services Program Providers for Appling County-Georgia (Check box below to select Provider)

☐B & B Care Services, Inc.

303 S. Laurel St.
P.O. Box 1040
Springfield, GA 31329
912-754-0817
www.BandBCare.com

☐Easter Seals Southern Georgia, Inc. *

Waycross Office
505 Elizabeth St.
Waycross, GA 31501
912-283-4691
www.southerngeorgia.easterseals.com
*Additional Offices in Albany, Valdosta, & Americus

☐Pineland Behavioral Health/ Developmental Disabilities*

Jesup Office
1848 South Sunset Blvd.
Jesup, GA 31545
912-427-4491
*Additional Office in Statesboro
www.pinelandcsb.org

Family Support Services
Services and Goods Funding Limits

Service/Good	Family Support Limit Annual Line Item Maximum	Prior Approval and/or Other Requirements	Medicaid Limit (Cannot Exceed)
Respite Care (Examples: Maintenance and Emergency)	$3,000 (Cannot exceed unit rates)	Licensed Respite Provider, Licensed BHDHH Provider, or Agency Approved Respite Provider	Day Limit -24 units Annual Limit 889 Maximum Rate- $4.21 Maximum $3,742.69 Overnight Annual Limit- 39 Maximum Rate - $96.00 Annual Rate -$3,744.00
Community Living Support (Examples: one on one in home assistance with activities of daily living)	$3,000 (Cannot exceed unit rates)	Licensed HRF Provider, Licensed BHDHH Provider, or Agency Approved CLS Provider	CLS- $22,921.60 Maximum per unit $4.93 Maximum per day $128.52
Community Access (Examples: individual or group teaching/coaching activities in a community setting.)	$3,000 (Cannot exceed unit rates)	Licensed HRF Provider Licensed BHDHH Provider, or Agency Approved CA Provider	CAG- $17,510.40 Maximum per unit $3.04 CAI- $10,454.40 Maximum per unit $7.27
Supported Employment	$3,000 (Cannot exceed unit rates)	Licensed BHDHH Supported Employment Provider	SEG-Monthly Limit 320 units Annual Limit 3840 units Maximum rate per unit- $1.80 SEI- Daily Limit 40 units Annual limit 1440 units Maximum rate per unit $7.26
Dental Services (Examples Dental Care, Cleanings, Extractions, Fillings, Caps, and general dental work. Excludes; Orthodontic Care, Veneers, Cosmetic Care.)	$3,000	Dental Services by a Licensed Dentist Lack of Coverage/ Insurance Denial	NA
Medical Care (Examples: Medical care that is necessitated for health and safety, and is not covered or denied by any other form of insurance, prescriptions, g-tubes supplies, Hearing aids, etc.)	$3,000	Medical Services By a Licensed/Registered Medical Provider Lack of Coverage/ Insurance Denial	NA

Family Support Services
Services and Goods Funding Limits

Service/Good	Family Support Limit Annual Line Item Maximum	Prior Approval and/or Other Requirements	Medicaid Limit (Cannot Exceed)
Vision Services (Examples Eye Care, Eye Exams, Eye glasses. Excludes; Contacts, designer frames, sunglasses)	$3,000	Vision Services Plan by a Licensed Optometrist Lack of Coverage/ Insurance Denial	NA
Specialized Clothing (Examples: specialized clothes and footwear, clothing designed with G-tube access openings, Weighted vests, etc. Note: Not off the rack.)	$1,734.48	Prescription or Identified Documented Disability Specific Items	Specialized Medical Supplies Annual Maximum $1,734.48
Specialized Diagnostic Services (Examples: diagnostic testing, psychological testing, neuropsychological testing, specialized assessments, and functional assessments)	$2,450.24	By a Licensed Professional: (Georgia Code 43: OCGA 43-10A-1) Psychologist LPC LCSW Psychiatrist	Annual Maximum $2,450.24
Recreation/Social Community Integration Activities (Examples: summer camps, scouting programs, gym membership, etc.)	$3,000	Camps within 50 miles from the Boarder of the State of GA. Family Memberships/Participation does not include programs that have individual enrollment processes, including but not limited to camps, scouting programs.	NA
Environmental Modifications (Examples: ramps, door widening for access, bathroom modification for access, etc. Must be disability specific)	$7,000 Lifetime Maximum	Prior Approval Required. Must have 3 quotes.	Lifetime Maximum $10,400
Specialized Equipment (Examples: breathing machines, wheelchairs, positioning boards, special chairs, hospital bed, portable ramps, weighted blankets, etc.)	$5,200 Annual Maximum $7,000 Lifetime Maximum	Prior Approval Required. Must have a prescription. Must have insurance denial letter. Must have 3 quotes.	Annual Maximum $5,200 Lifetime Maximum $13,474.76

Georgia Department of
Behavioral Health and Developmental Disabilities

Easy Access to High Quality Care

Family Support Services
Services and Goods Funding Limits

Service/Good	Family Support Limit Annual Line Item Maximum	Prior Approval and/or Other Requirements	Medicaid Limit (Cannot Exceed)
Therapeutic Services (Examples: Audiology, Physical, Occupational, Speech and Language etc.)	$1,800 Maximum	Licensed Occupational Therapist Licensed Physical Therapist Licensed Speech and Language Pathologist Must go through the school system first if under 22.	Annual Maximum $1,800
Counseling (Examples: Behavioral, Mental Health, Psycho-Social, Family, etc.)	$2,450.24 Maximum	By a Licensed Professional: (Georgia Code 43: OCGA 43-10A-1) Psychologist LPC LCSW Psychiatrist	Annual Maximum $2,450.24
Parent/Family Training (examples: One Time or On-Going Classes/Trainings/Conference to educate families regarding Intellectual and Developmental Disabilities)	$1,787.08 Maximum	NA	Maximum per unit $20.78 Annual Maximum $1,787.08
Specialized Nutrition (Examples: ensure, food supplements, dietary needs, etc.)	$1,734.48 Maximum	Prescription from Dr., Nurse Practitioner, or Nutritionists	Specialized Medical Supplies Annual Maximum $1,734.48
Supplies (Examples: Protective chucks, Ancillary supplies for specialized equipment maintenance, specialized batteries for specialized equipment, etc.)	$1,734.48 Maximum	NA	Specialized Medical Supplies Annual Maximum $1,734.48
Incontinent Supplies (NOTE: ONLY INCONTINENT SUPPLIES WORN ON THE BODY. Examples: diapers)	$1,734.48 Maximum	Georgia Medicaid Recipient age 4-21 must first attempt to access services through a Medicaid vendor, a prescription for incontinent supplies is required.	Specialized Medical Supplies Annual Maximum $1,734.48

Revised 15.04.23

Family Support Services
Services and Goods Funding Limits

Service/Good	Family Support Limit Annual Line Item Maximum	Prior Approval and/or Other Requirements	Medicaid Limit (Cannot Exceed)
Behavioral Consultation and Support	$2,450.24 Maximum	Behavior Specialist, Board Certified Behavior Analyst, or Psychologist and any additional criteria listed in NOW Part III –Chapter 1600	Maximum per unit $23.56 Annual Maximum $2,450.24
Financial and Life Planning Assistance (Examples: budgeting planning, understanding trusts, understanding the process of planning for the future, etc. Excludes: Paying for trust, guardianships)	$1,200 Maximum	See Provider Manual	$75.00 per month $1,200 annual
Exceptional Disability Related Living Cost (Example: cost difference of utility bills for those individuals with heat and cold sensitivity.)	$3,000	See Provider Manual	NA
Homemaker Services (Example: light household work or tasks, when primary carer unable.)	$3,000	See Provider Manual	NA
Family Support Transportation Family Reimbursement (NOTE: Provider sets reimbursement rate; must not exceed State Rate)	$3,000	Travel must be over 100 miles round trip for medical reasons, or activities and services beyond the scope of the family's normal responsibilities.	NA
Family Support Transportation Community Integration Transportation (Example: Public Transit (bus/train) passes Excludes: taxi services reimbursement)	$1,200	The family/individual cannot have access to a vehicle, and all natural supports for transportation assistance must be exhausted. This transportation assistance must increase the family/individual's access to the community to ensure community stabilization.	NA

Family Support Services
Services and Goods Funding Limits

Service/Good	Family Support Limit Annual Line Item Maximum	Prior Approval and/or Other Requirements	Medicaid Limit (Cannot Exceed)
Family Support Transportation Provider Reimbursement	$2,797.34 Maximum	See Provider Manual Exceptions: i. Community Living Support ii. Community Access iii. Supported Employment	Unit = One way trip Annual Limit = 203 units Maximum rate per unit $13.78 Annual Maximum $2,797.34
Vehicle Adaptation Services (Example: hydraulic lift, ramp, special seats, etc.)	$5,000 Lifetime	Prior Approval Required. Must have 3 quotes. Does not include the cost related to the purchase of a vehicle.	Lifetime Maximum $6,240.00
Child Day Care/After-School Services	$3,000 Maximum	See Provider Manual	NA
Other Family Support Services (NOTE: Request for rental assistance and/or utility assistance is only available one time per fiscal year, per household, and after all other resources have been exhausted.)	$3,000	Prior Approval Required	NA
Family Support Coordination Rate	529.44 annual Maximum 44.12 Monthly Unit	Active IFSP	NA

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

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

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: _____

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

Check if Same as Individual

Street Address: _____

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	

Name (Individual receiving services)_____

Please complete this questionnaire to the best of your ability, and sign. This will assist in developing your individuals Family Support Plan for the Fiscal Year, and will determine his/her service categories and funding allotments.

1. What makes your individual happy? What makes him/ her smile? (this can be favorite food, places, people, things)

2. What are your hopes and expectations for you individual? What do you want to be sure they have access or exposure to?

3. Do you ever get stressed out and feel overwhelmed with caring for your individual? If so, explain what your stressors may be.

4. Family dynamics- Who are the members currently living in the household Ex: brother, sister, mother, father, aunts, grandmother/father, etc)

5. What activities does your individual, or family as a whole currently take part in outside of the home?

6. Do you ever find yourself paying out of pocket expenses related to medical, dental or vision care?

7. Does your individual require any type of specialized clothing as a result of his/ her disability? If yes, explain.

8. Would your individual benefit from taking part in more activities in the community? Please list activities he /she may be interested in.

9. Would your family benefit from structural changes made to your home which would allow more accommodation to his/her needs? (fencing for flight risks, wheelchair ramps, door widening, bathroom modifications, etc.) Explain.

10. Would your individual benefit from any assistive technology (if not school age) or other specialized equipment? Note: School age children should be provided assistive technology needs through their IEP.

11. (if not school age) Would your individual benefit from any type of therapeutic services such as physical, occupational or speech therapy? Counseling (family or individual)? Note: School age children should be provided therapies and counseling needs through their IEP.

12. Has your individual been prescribed any type of specialized nutrition such as Ensure, PediaSure or Boost? Does your individual use a feeding tube? If so, is your individual receiving this supplement through any other source such as Medicaid or other source? (If so, please include a copy of the prescription and complete table below)

Type	Frequency	Provided by another source such as Medicaid or private insurance?
		☐ yes ☐ no

13. Does your individual use any type of incontinence supply (diapers, wipes, gloves, chux, etc)? If so, please list specific brand/ size of diapers/ wipes/ chux/ gloves and how many of each are used in a typical day. If your individual uses any other incontinence supplies not listed below, please add In available spaces.

	Circle one	Preferred Brand/ Type	Size	Hip Measurement in inches	How many are used in a typical day?	Provided by any other source
Diapers (tab type)	Yes No					Yes No
Pull-Ups	Yes No					Yes No
Wipes	Yes No					Yes No
Chux (underpads)	Yes No					Yes No
Gloves	Yes No					Yes No

14. Have you ever been unable physically to take care of housekeeping needs?

15. Do you ever travel over 50 miles round trip to transport your individual to appointments or procedures?

16. Would you benefit from accommodations such as (lifts or ramps) made to your vehicle in order to transport your individual? If yes, explain.

17. Does your individual require after school care or daycare? If so, have you applied for CAPS? Note: In order for Family Support to provide assistance with child care/ after school care, we must have a CAPS denial letter on file. CAPS can be applied for online at www.compass.ga.gov

18. Do you have an email address? If so please list it here:

_____

I _____ have answered these questions honestly, and to the best of my ability. I understand that the answers to these questions will determine the level of support my individual receives through the Family Support Program. I understand that Family Support is not an entitlement program and is to be used only as a payer of last resort. All other funding options must be exhausted before utilizing Family Support Funding.

Signature_____ Date_____

Thank you for your interest in State Funded Family Support services provided through Pineland Community Services!

PLEASE READ THIS PAGE IN ITS ENTIRITY BEFORE STARTING TO COMPLETE APPLICATION!

Included in this packet you will find everything you need to apply for and potentially begin your Family Support Services. Below is a checklist for you to determine if you or your loved one is eligible for services.

____Do you or your loved one have a diagnosis of a developmental or intellectual disability which limits intellectual functioning? ***** Note - a diagnosis of ADD, ADHD, Vision, Hearing or Speech ALONE does not qualify your individual for FS Services. There MUST be deficits in INTELLECTUAL functioning.**

____ Do you reside in one of the following counties: Appling, Bulloch, Candler, Evans, Jeff Davis, Tattnall, Toombs or Wayne?

NOTE: If you or your loved one are receiving Family Support services from another provider such as Easter Seals, B&B, Etc. you are NOT eligible for services through Pineland. Only ONE provider may be utilized for services.

NOTE: If you or your loved one are currently receiving services through a NOW or COMP Medicaid Waiver, you are not eligible for services.

For more information on eligibility please visit: https://dbhdd.georgia.gov/family-support-services

INSTRUCTIONS FOR COMPLETING APPLICATION

****IMPORTANT** - Please COMPLETE each field of the application. Please SIGN AND/OR INITIAL in all designated areas.

Absolutely no applications will be considered without social security number.

The following items MUST BE INCLUDED in order for your application to be considered for approval.

As many as possible, but no less than TWO of:

- Psychological Evaluation (preferred)
- COMPLETE IEP from school system (preferred)
- Medical Verification from diagnosing physician
- Developmental Disabilities Intake & Evaluation Assessment (completed by DBHDD staff)
- Social Security Determination (with diagnosis discussed)

Note: If the individual applying for services is above the age of 18 (or will be 18 before upcoming July 1st), a copy of certified birth certificate or a copy of a state issued ID card must be included.

Please return completed application packets to: (If mailing, faxing or emailing, please use first option)

Ty S. Drury Pineland – Wayne Service Center 1848 South Sunset Blvd Jesup, GA 31545 Phone: 912-681-1837 Fax: 912-427-4791 Email: tstanfield@pinelandcsb.org	Dawn Edenfield Pineland Community Services 5 West Altman St Statesboro, GA 30458

Pineland DBHDD FY19
Individualized Family Support Plan (IFSP) Annual Review

Name: Karen Tharpe DOB: _____

Parent/Guardian Name (if applicable): _____

Address: 249 Blackshear Highway / Baxley, GA 31513 County: _____

Phone: 912-367-8600 ext. 166

Eligibility Redetermination

Eligibility Criteria

X Developmental Disability Diagnosis: _____
X Residing in Family Unit
X County of Residency within Agency Catchment

Ineligibility Criteria

_____ Receiving Family Support Services from any other Provider/Agency
_____ Receiving NOW/COMP Waiver Services
_____ Currently residing in an inpatient or skilled nursing facility

Person-Centered Profile

Individual

1. What is important ***to*** you? _____
2. What is important ***for*** you? _____

Family

3. Describe the family dynamics: _____

Support Network

4. Describe the family's support network: _____

Physical Environment

Describe the physical environment that the individual lives in, and participates in regular activities within the community (i.e. school, work, recreation, etc.):

_____
_____
_____

Current Services

5. List all current services/resources utilized by the individual and family:

Service/Waiver/Program	Funding Source	Description/Funding Level

Unmet Needs

6. Describe the unmet needs of the individuals and families that are disability specific: _____

_____

_____

Pineland DBHDD FY19
Individualized Family Support Plan (IFSP) Annual Review

Summary of Outcomes

Service/Good	Describe the Outcome/Achievement/Benefit of the Family Support Service/Good:

Individualized Services and Goods

Start Date: _____ End Date: _____

Service/Good	Description/Justification	Available through any other funding source	Frequency/ Duration	Annual Cost
			TOTAL ANNUAL BUDGET:	

Describe any changes to the services and goods from previous plans and provide justification for any changes:

Pineland DBHDD FY19
Individualized Family Support Plan (IFSP) Annual Review

SIGNATURES

Family Support Agreement Signed: ☐ Yes ☐ No

I/We attest that we were informed of our right to participate in the development of this Individualized Family Support Plan, and were given the ability to make any changes to the services and goods identified based on my/our family priority of needs for services/goods. . I/We understand that Family Support Services is a non-entitlement program and Pineland DBHDD cannot fund all the service and goods that I/We may request, and that funding levels can and might change from each funding year and are subject to funding limitations.

I/We agree with the Individual Family Support Plan, Family Support Agreement, and the disclaimers above:
☐ Yes ☐ No

Signature	Date
Parent/Guardian Signature	Date
Other/ Title	Date
Family Support Coordinator Signature	Date

FAMILY SUPPORT GOODS AND SERVICES REQUEST

This space for internal use only

COUNTY :_____

☐ IB
☐ FYB
☐ BSS

Revised 7-1-17

Date of Request: **Individual Requesting:** **Phone:** 912-367-8600 ext. 166 **For (Individual Name):** Karen Tharpe **Address:** 249 Blackshear Highway / Baxley, GA 31513 **Phone:** **Date of Birth:** **Email address:** ***Do you own or rent your home?	**Check Payable to:** **Address:** **Amount:** **Please return to:** **Ty S. Stanfield** **Family Support Coordinator** **Pineland BHDD** **Phone: (912)681-1837 Fax: (912)427-4791** **Email: tstanfield@pinelandcsb.org**

Please provide a short description of the item/service you are requesting as well as an estimated price. (please include any item numbers, web addresses, etc:

The goal of Family Support is to sustain and enhance the quality of family/home life so that the individual with developmental disabilities can remain within a nurturing family in his/her home. Please provide a short description of how this item will make a positive difference in the life of the person with a disability as well as the lives of all family member.

Have there been any changes in services received from other sources since your application for Family Support was submitted to the region? Yes___ No__X__
If yes please provide explanation below:

_____

_____

I declare that the above requested items are not made available to me, or to my family though any other source.

Signature of Applicant/ Guardian_____Date_____

Please do not write below this line. For Office Use Only.

Approved___ Denied___ Family Support Coordinator: _____Date_____
Approved___ Denied___ Financial Department: _____Date_____
If denied, state reason here:

_____

Expense Account number: _____ CC type and #:_____
Date Paid: _____ Check #:_____

Pineland Behavioral Health and
Developmental Disabilities

Karen Tharpe
Name of Individual

Social Security Number AND/OR Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION- STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: **Pineland Behavioral Health & Developmental Disabilities – Family Support Program**
(Name of health care provider holding the information-releasing agency)

1848 South Sunset Blvd, Jesup, GA 31545-7810 **912-427-4491**
(Address) (Phone/Fax)

To: _____
(Name of Person or Agency to whom information should be given-requesting agency)

_____
(Address) (Phone/Fax)

_____ I authorize the following information from my records (and any specific portion thereof):
Initials Name, Mailing Address, Phone number for purpose of payment for / shipping of goods/ services funded by Family Support

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

_____
Initials

_____ I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus)
Initials and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions

The above information is for the purpose of:: Family Support

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 the Agency 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.

Date **Signature of Individual**

Signature of Witness (Title or Relationship to Individual) **Signature of (check one):**
☐ **Parent** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor**
☐ **Agent designated by Individual's Advance Directive**

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Suite 22.240 Atlanta, GA 30303-3142.

Date this authorization is revoked by Individual **Signature of Individual or legally authorized Representative**

PINELAND BHDD FAMILY SUPPORT
TRAVEL EXPENSE REPORT

The Family Support travel reimbursement mileage rate for medical is .235 per mile. As of July 1, 2014, Pineland will be reimbursing Family Support medical travel at this rate. Please make sure all of your individuals on family support use this revised form. Information completed on the incorrect form (after today's date) will be returned without payment.

The rate for Meal reimbursement is as follows:

Breakfast **$6.00** *(MAX $12.00)*
Lunch **$7.00** *(MAX $14.00)*
Dinner **$15.00** *(MAX $30.00)*

Meals will be reimbursed for **the individual** and ***ONE*** caretaker.

Supporting documentation to submit with travel expense report for reimbursement:

Receipt(s) from gas purchases *(please be sure to get receipt when paying cash as well)*
Receipt(s) from food purchases *(breakfast, lunch and/or dinner)*
Appointment card
Discharge paperwork
Work or School Excuse
Lodging expenses *(hotel, motel, etc.)*

PINELAND BHDD FAMILY SUPPORT
TRAVEL EXPENSE REPORT (Please type or print)

Check Payable to:	Consumer Name:
Address (Residence):	
County:	Phone number: 912-367-8600 ext. 166

Date		Departure Time	Return Time	*Breakfast* MAX $6 per person (Individual and caregiver)		*Lunch* Max $7 per person (Individual and caregiver)		*Dinner* MAX $15 per person (Individual and caregiver)		Total Meal Amts. Claimed
Month	Day			Location	Amt. Claimed	Location	Amt. Claimed	Location	Amt. Claimed	
								TOTAL MEAL AMOUNTS CLAIMED		

Date		Departure Time	Return Time	Lodging		Total Lodging Amts. Claimed
Mth.	Day			Location	Amt. Claimed	
					TOTAL LODGING AMOUNTS CLAIMED	

Receipts for food and lodging must be attached.	**Total Meals & Lodging** (Attach Lodging Receipts):	
A doctor's excuse or appointment card must be attached for mileage reimbursement.	**Common Carrier Expenses** (write description of expense below):	
Parent/Guardian Signature: **Date:**	**Miscellaneous Expenses** (Write description of expense below):	
Family Support Coordinator Signature: **Date:**	***Complete Automobile Mileage record below with detailed trip information*** **Total miles _____ at .235 cents per mile.**	
Final Approval (Pineland Admin. Use Only) **Date:**	**TOTAL EXPENDITURES**	

AUTOMOBILE MILEAGE RECORD

Month (Ex: Sept = 09)	Day of the Month	Beginning Odometer Mileage (whole numbers only)	Destination	Ending Odometer Mileage (whole numbers only)	Total Mileage

Revised 092015

PINELAND COMMUNITY SERVICES

Other Category Assistance Worksheet

Once this worksheet is completed, your request will be considered by the regional office for prior approval. Please keep in mind that requests can take as long as ten business days (two weeks) to obtain approval once processed to the regional office. If the hardship is due to medical reasons, please add documentation of this to the request. According to the reasoning provided, the region may ask for additional supporting documentation.

1. Please list the expenses you are currently requesting assistance with and amounts. Please keep in mind that no assistance will be provided for any items which could be considered luxury items such bills related to cell phones cable or satellite tv, internet, etc.

VENDOR	AMOUNT DUE	SCHEDULED FOR INTERRUPTION?

2. Please explain the detailed reason you have encountered this hardship/ what has caused you to become delinquent on these bills.

3. Please explain your detailed plan of action regarding how you will pay for these expenses in the future months. Please keep in mind that this assistance can only be provided one time per fiscal year, and is not guaranteed.

Signature of Individual Requesting _____ Date_____

Relationship to Individual Receiving Services_____

Name of Individual Receiving Services_____

Current Address_____

Current Phone Number_____