Tennessee Family Support Program
2020-2021 Application

The **Tennessee Family Support Program** is a grant program funded through the Department of Intellectual and Developmental Disabilities {DIDD}. Funding is available for services and supports that are not otherwise covered by insurance or other resources. Please refer to our website for more information about services and supports covered by the Family Support Program.

The program is limited to State of Tennessee residents who have a severe disability {see below} that is permanent and results in significant limitations in their daily life. Funding is available to eligible individuals of *all ages and income levels*.

The primary focus of the Family Support Program is to provide services to those who:
1) Were born with a severe or developmental disability or acquired it in childhood
2) Have been severely disabled by injury or trauma {brain injury, spinal cord injury, loss of limbs}
3) Or have a neurological/neuromuscular disorder {ALS, Muscular Dystrophy, or Multiple Sclerosis}

Due to limited funding, not all applicants who are eligible may be selected to receive funding.
Applicants are not guaranteed to be selected for funding from year to year. Selection will be based upon priorities set forth by the District 3 Family Support Council.

Although applications are accepted year-round, open application period is January 1st thru March 30th of every year. The fiscal year 2020-2021 will begin July 1, 2020 and end June 30, 2021. Funding will not be available until after July 1, 2020. Approval letters will be mailed no later than August 15, 2020.

Please note:
Individuals who are enrolled in the Katie Beckett Waiver, ECF Choices Program, DIDD Waiver Program, TennCare Choices Program or Pace Program are not eligible to receive Family Support Program Funding. *Mental illness and aging related disabilities are not covered by the Family Support Program.*

Open Application Deadline for fiscal year 2020-2021 is March 31, 2020

Questions? *We are here to help!*

Visit: www.familysupporttn.com
Email: familysupport@orangegrove.org
Call: 423-664-5120 (Kristi)

Application Checklist:

The following documents are required to apply for the Family Support Program.
**Your application cannot be processed until all documents are received by our office.*

- ☐ **Intake & Application {attached}**: It is very important that you provide as much information as possible to assist us in determining your eligibility and selection for the program.

- ☐ **Proof of Tennessee Residency**: Required annually for all applicants. Documents must be dated within the last 60 days and must be an original document {unaltered}. Please submit one of the following showing the name & address of the applicant {not spouse or parent}:
  Utility bill (electric, gas, water, or cable), Mortgage or rental agreement, SSI or SSDI letter, TennCare or other insurance letter/bill, Current IEP {child applicant's only}

New Applicants must also submit the following:

- ☐ **Proof of Severe Disability:** All applicants must submit a statement from their physician that includes their disability and diagnosis.

- ☐ **Proof of U.S. Citizenship:** The State of Tennessee requires that we have proof of citizenship for all Family Support Applicants. Please submit one of the following: U.S. Birth Certificate, Certificate of Naturalization, or Certificate of Citizenship.

All documents must be mailed.

Faxed, emailed copies will not be accepted.

Family Support Program
c/o Orange Grove Center
615 Derby Street
Chattanooga, TN 37404

Department of Intellectual and Developmental Disabilities
Family Support Intake Form

Date _____

Name of Family Member with a Severe or Developmental Disability _____

Social Security# _____ Date of Birth _____

Name of Primary Family Member(s) (if different than above) _____

Family's Address _____ Phone _____

_____ Phone _____

County _____ Email Address _____

Reason for Referral to Family Support Services (include information on the impact of disability on family)

_____

Potential Support Services Needed/Requested (Check services needed):

☐ Before/After Care	☐ Home Modifications	☐ Specialized Equip. & Repair/Maintenance	☐ Recreation/Summer Camp
☐ Behavior Services	☐ Home Maker Services	☐Specialized Nutrition/Cloth/ Supplies	☐ Vehicle Modifications
☐ Day Care	☐ Nursing/Nurses Aide	☐ Training	☐ Other: _____
☐ Emergency Living Expenses	☐ Personal Assistance	☐ Transportation	☐ Other: _____
☐ Family Counseling	☐ Respite	☐ Health Related	☐ Other: _____

Is the Individual or Family Currently Receiving Other Services (Check all that apply)?

☐ Adoption Assistance	☐ Medicaid	☐ Residential Services	☐ TennCare
☐ CHOICES Waiver	☐ Medicare	☐ Social Security Income	☐ Vocational Rehabilitation
☐ DIDD Waivers	☐ Nursing Services	☐ Social Security Disability Income	☐ PACE
☐ Food Stamps	☐ OPTIONS Program	☐ Supported Living	☐ Other: _____
☐ Foster Care	☐ Private Insurance	☐ Tenn. Early Intervention System	☐ Other: _____

To comply with Title VI the following information is requested:

☐ Caucasian	☐ African-American	☐ Hispanic	☐ Other
☐ Female	☐ Male		

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

Name of individual making referral to Family Support _____

Agency _____ Phone _____

Address _____

Primary Disability – Check which of the following major disability categories is most relevant to the family member with a severe disability as a primary diagnosis:

☐ Autism
☐ Cerebral Palsy
☐ Deaf and/or Blind
☐ Health Impairment
☐ Traumatic Brain Injury
☐ Other
☐ Intellectual Disability
☐ Neurological Impairment
☐ Orthopedic Impairment/ Physical Disability
☐Spinal Cord Injury
☐ Developmental Delay (Birth - 8 y.o.)

Did the person's primary disability occur:

☐ Prior to age 22
☐ At age 22 or after

By signing and dating this Intake Form, I the person supported or legal representative indicate that all of the information above is correct.

_____ _____

Signature of Person Supported or Legal Representative Date

If someone other than family/individual completed form:

How was this information obtained (ie. face to face visit, by phone)?

_____

NOTES

_____

_____

_____

_____

_____

DIDD-6004

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Has the applicant previously received Family Support Program funding? **YES** **NO**

Does the applicant have a diagnosis of intellectual disability (diagnosed prior to age 18)? **YES** **NO**

Has the applicant applied for or plan to apply for the TennCare ECF Choices Program? **YES** **NO**

Has the applicant applied for or plan to apply for the Katie Beckett Waiver ? **YES** **NO**

Please describe the nature of the disability including diagnosis and severity:

_____

_____

_____

Please describe how the applicant's disability affects their daily life:

_____

_____

_____

Please list All services (respite, personal assistance, nursing, day programs, etc…) provide by other agencies. Please indicate who is paying for each service (insurance, grant program, scholarship, private pay, etc.)

_____

_____

_____

Please describe the applicant's current living situation:
(Who does the applicant live with? Who provides care for the applicant?)

_____

_____

How many people live in the home? _____ How many are under 18 years old? _____

Is the primary caregiver 75 years old or older? **YES** or **NO**

Are there other individuals with disabilities residing in the home? **YES** or **NO**

If **YES**, please describe relationship to the applicant and nature of disability:

_____

1. **Applicant's Self Care & Daily Living Skills:**

Please check applicable box for each activity of daily living skill.	Needs Total Assistance	Needs Some Assistance	No Assistance Needed
Eating			
Dressing			
Bathing			
Toileting			
Transfers in/out of bed or wheelchair			
Preparing Meals			
Making medical appointments			
Shopping for groceries, medications			
Completing household tasks/cleaning			
Managing money			

2. **Applicant's ability to Communicate:**

Is the applicant's ability to communicate affected by their disability? **YES or NO**
If **yes**, how does applicant communicate with others? _____

_____

Does the applicant have difficulty understanding verbal instructions? **YES or NO**

3. **Applicant's ability to learn:**

Is the applicant's ability to learn affected by their disability? **YES or NO**
If **yes**, please describe how learning is affected: _____

_____

Is the applicant receiving special education services (or have received in the past)? **YES or NO**

4. **Applicant's Mobility** (ability to walk and move around their home/community)**:**

Is the applicant's mobility (walking) affected by their disability? **YES or NO**
If **yes**, how is mobility affected? _____

_____

Does applicant require a wheelchair or other supportive device? **YES or NO**

If **yes**, please describe supports needed: _____

5. **Applicant's Self Direction:**

Does the applicant need constant supervision due to safety concerns? **YES or NO**
Is the applicant aware of danger? **YES or NO**
How does the applicant's disability affect their judgment and ability to make decisions? _____

_____

6. **Economic:**

How does disability affect the applicant's ability to work? _____

_____

Please note that you are applying for funding that will not be available until after July 1, 2020.
Any services that occur prior to July 1, 2020 cannot be requested with this application.

What is funding being requested for? Please describe in detail and include amount of funding needed/requested. Please include estimates for all items, if applicable. If multiple items are requested, please list in order of priority and include cost of each item.

_____

_____

_____

_____

_____

_____

The Family Support Program does not provide funding for purchases made prior to request and approval of funding.* **Total Funding Requested: $_____

Are you receiving funding/assistance from any other source (TennCare, Medicare, private insurance, scholarships, grants, etc…) to help pay for the service you are requesting? **YES or NO**

If YES, answer all of the following:

Who is providing funding? _____

How much funding is being received? _____

Why is funding also needed by the Family Support Program?

_____

_____

_____

_____

By signing this application, you agree that all of the information provided is accurate to the best of your knowledge. Any attempt to provide false or misleading information will result in immediate termination of funding from the Family Support Program.

_____ _____ _____

Signature of person completing application Relationship to applicant Date