Tennessee Family Support Program
2021-2022 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 <u>and</u> 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}

<u>Due to limited funding, not all applicants who are eligible may be selected to receive funding.</u> 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 April 15th of every year. The fiscal year 2021-2022 will begin July 1, 2021 and end June 30, 2022. Funding will not be available until after July 1, 2021. Decision letters will be mailed on/around August 1, 2021.

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

Questions? *We are here to help!*

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

Please submit all documents no later than April 15, 2021

TN Family Support Program @ Orange Grove Center provides funding for Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea, and Sequatchie Counties

Follow us on Facebook! www.facebook.com/FamilySupportOGC

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.

Please submit all documents no later than April 15, 2021

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

TN Department of Intellectual & Developmental Disabilities | Family Support Program

Family Support Program - Intake Form

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Date:________________ County of Residence: ________________________________

Person with severe/developmental disability applying for Family Support: ____________________________________

Social Security # ________/______/________ Date of Birth: _____/______/________

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
- ☐ Tennessee Early Intervention System (TEIS)
- ☐ PACE (Program of All-Inclusive Care for the Elderly)
- ☐ OPTIONS Program
- ☐ 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 ☐ TBI Grant ☐ Katie Beckett Program
☐ Any in home or community supports ☐ None

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

☐ Male ☐ Female
☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other ☐ Unknown

TN Department of Intellectual & Developmental Disabilities | Family Support Program

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

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

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 fraud and may result in 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: ____

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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:

____

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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.)

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

____

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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, 2021.
Any services that occur prior to July 1, 2021 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.

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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, Katie Beckett Waiver, 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?

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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

Please submit all documents no later than April 15, 2021