Virginia Department of Behavioral Health & Developmental Services

Maximum Amount of Request is $1000

Applications must be postmarked on or after September 15, 2015

If you need help completing the application in another language, please call 804-225-3810 or 804-663-7277

FY 2016 Individual and Family Support Program

Part I: APPLICANT INFORMATION (the individual on the waiting list)

Name _____ Social Security Number: _____

Date of Birth / / MM/DD/YYYY ☐Male ☐ Female

Which waiting list is the applicant on? ○ DD Waiver ○ ID Waiver **Urgent** ○ ID Waiver **Non-Urgent**

Address _____

Street City Zip Code County

Best telephone number to reach you _____

Part II: RESPONSIBLE PARTY (the individual or person filling out application who will be responsible for IFSP funds)

Name _____ Social Security Number: _____

Date of Birth / / MM/DD/YY ☐Male ☐ Female

Address _____

Street City Zip Code County

Best telephone number to reach you _____

e-mail address_____

Part III: WAITING LIST INFORMATION (choose one)

☐ I am an **individual** with intellectual/developmental disabilities who is on a ***waiting list*** for services.

☐ I am a **family member** of a child or individual with an intellectual/developmental disability who is on a ***waiting list*** for services.

If you are a family member, does the individual live with you on a permanent basis?

☐ Yes ☐ No If no, please give details: _____

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If you listed yourself above as a family member, what is your relationship to the individual for which you are applying?

☐Mother ☐ Stepmother ☐Wife ☐ Grandmother ☐ Sister ☐Father ☐Stepfather ☐Husband ☐Grandfather
☐Brother ☐ Principal Caregiver ☐Other _____

Part IV: ASSISTANCE AND RESOURCES

How did you hear about the Individual and Family Support Program?

☐ Case Manager/Support Coordinator ☐ Consumer Directed Services Facilitator
☐Center for Independent Living ☐ List serve
☐ Parent/Advocacy Group (_____) ☐ Website (_____)
☐ DBHDS Web-site

DO NOT FAX THIS APPLICATION. DO NOT HAND DELIVER IT TO THE IFSP OFFICE. IT WILL NOT BE ACCEPTED!

- If approved, you will be required to provide documentation for supports and services ***after*** the funds have been used and paid.
- If your needs change but they still meet the requirements of the IFS Program, you DO NOT have to ask for approval before spending your allocated funding.
- To ensure proper credit once funds are used, *you are required to provide receipts and any other documentation* to the IFS Program that support how funds were spent. Ensure that the name of the individual on the waitlist is written on the top of each page sent.
- You may mail, e-mail, OR FAX your receipts (only) to the IFS Program. Fax number 804-786-0076.
- Failure to follow the above procedures will impact your ability to receive future funding from the IFS Program.

Part V: Needs

1) Please select categories and specific items/services needed during the next 12 months.
2) IN TWO OR THREE SENTENCES, describe how each item, will assist you to stay in your home.
   a. There is no need to attach doctor's reports or orders, or to attach multiple pages of information on the individual's condition.
3) Write down the requested funding amount total for each Category.
4) Write down the Total Requested Amount, no more than $1000.

Emergency Supports: (Prevent Hospitalization, Reduce Risk of Homelessness or Institutionalization/Other, Rent & Utilities) (Provide proof of rent amount and copy of your utility bills) **Amount_____**

_____

_____

_____

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Safe Living Environment (Respite, Wheel chair Ramp, Bath/Home Modifications, Fence, Generators, Home Security, Project Lifesaver & Bedding) (Provide Quotes from Contractors for Home Modification or Provide a breakdown: ex: $10 per hr x 5 hr a day for 5 days a week for Respite) Amount_____

_____

_____

_____

Improved Health Outcomes (Attendant Care, Dental/Eye/Hearing Exams, Medications Nutritional Support, Personal Care items, Therapies ABA, OT/PT Speech, Hippo, Modified Equipment, Communication, Device, Other) (Breakdown Attendant Care &Therapies: ex $40 per hr x 3 hrs a day x 2 days a week. Provide internet printouts for equipment and devices with the cost.) Amount_____

_____

_____

_____

Community Integration (Child Care, Day Support, Camp, Peer Mentoring Therapeutic Recreation, Transportation Services, Supported Employment, Self Advocate Training. (Break Down support services. ex: $10 per hr x 5 hrs a day for 5 days a week. Provide printouts of Camps, Training and Supported employment with cost)

Amount_____

_____

_____

_____

Total Requested Funding from all Categories (no more than $1000): $_____

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PAYMENT OPTION: IF YOU NEED YOUR PAYMENT TO GO DIRECTLY TO A BUSINESS OR A VENDOR, PLEASE FILL IN THE INFORMATION BELOW:

Each Vendor or business must complete a W9 (Sample W9 on web-page) and it must be submitted with your application.

Information on Vendor /Individual who will be providing the service:
Name _____
Address_____
City_____ State_____ Zip Code_____

Social Security Number of person providing the service (REQUIRED) _____

Part VI: PROGRAM AGREEMENT (Signature required)

READ AGREEMENT CAREFULLY:
This is an agreement between the Applicant/Responsible Party and DBHDS. The Applicant is eligible only if the individual with an intellectual or developmental disability is residing in his own home or the family home and is on the statewide waiting lists for the Intellectual Disability Medicaid Waiver or the Individual and Family Developmental Disabilities Services Medicaid Waiver.

The Applicant agrees as follows:

- The Applicant acknowledges that the IFSP funds are provided only to the extent that such services are not available or cannot be funded through other public funding sources (including IDEA Part C - early intervention, IDEA Part B - public school services, Medicaid, Medicare, and EPSDT).
- The Applicant acknowledges that all money received through IFSP will be used solely for the purpose(s) documented on the Applicant's IFSP Application.
- The Applicant acknowledges that he/she must present receipts or other documentation to verify that IFSP funds were used to purchase only approved services or items and shall include the name of the provider of the goods/services and the individual's name. Any misrepresentations of the use of IFSP funds or attempts to misappropriate these funds are strictly prohibited and subject to legal action.
- The Applicant acknowledges that failure to provide documentation that IFSP funds are used to purchase only approved services or items may result in recovery of such funds and denial of subsequent funding requests.

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- The Applicant acknowledges that any misrepresentation of the individual's/family's needs, and misappropriation of funds will result in immediate discontinuation of funding, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s). The individual may also no longer have access to IFSP funds in the future.
- The Applicant agrees to permit DBHDS representatives to conduct utilization reviews, including home visits, and shall cooperate fully with such reviews and provide all information requested by DBHDS.
- The Applicant acknowledges that IFSP funding is neither an entitlement nor a grant, and is provided to assist the individual to live at home with his/her family or independently in the community while waiting for waiver services.
- I have read, understood and agree to the terms and conditions of the Individual and Family Support Program and that all information provided is true and accurate to the best of my knowledge.
- _____

Signature (Financially Responsible Person) Date