New Horizons Behavioral Health
Building Better Lives

A Community Mental Health / Developmental Disabilities / Addictive Diseases Program

Intellectual/Developmental Disabilities
Family Support Program
919 Lawyers Lane
Columbus, Georgia 31906
(706) 256-3200
familysupport@nhbh.org

Dear Family Support Applicant,

Thank you for your interest in the Family Support Program with New Horizons Behavioral Health.

Attached you will find an application and agreement for services. Please read the application thoroughly and respond accordingly. Once you have completed your application and agreement, please bring the completed forms to our office *(address above)* along with the following documentation required by the regional office:

- Psychological Evaluation(s)
- Most recent IEP *(if applicable)*
- Birth Certificate
- Social Security Card
- All Insurance Cards
- 2 forms of address verification
  (one must be a current t financial verification such as a lease or mortgage statement, the second must be a current utility bill)

Please write your initials beside each statement on the Family Support Services Agreement to acknowledge your consent.

Don't be discouraged, the application process can take up to 30 calendar days AFTER we have submitted it to the regional office. Once we have an approval or denial from the regional office, you will be contacted by one of the Family Support staff. Should you have any questions or concerns, please feel free to contact our office at your convenience.
Again, thank you for your interest and we look forward to speaking with you soon!

Family Support Staff
New Horizons Behavioral Health

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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 EndDate:** _____

INDIVIDUAL/ APPLICANT INFORMATION

Individual Name: _____

Individual Date of Birth: _____

Individual Social Security Number: _____

Individual Address: _____

Street Address: _____

Street Address: _____

City, State, Zip: _____

Individual Phone Number: _____

Name of Family Member: _____
(Person Applying on behalf of Individual)

Relationship to Individual: _____

Family Member's Address: _____

Street Address: _____

Street Address: _____

City, State, Zip: _____

Check if Same as Individual ☐

Family Member's Phone Number: _____

Check if Same as Individual ☐

PROVIDER INFORMATION

Provider/ Agency Name: New Horizons Behavioral Health - Family Support Services

Provider/Agency Address: 919 Lawyers Lane, Columbus, Georgia 31906
Street Address: _____

Street Address: P.O. Box 5328,

City, State, Zip: Columbus, Georgia 31906

Provider/Agency Phone Number: (706) 256-3200

Provider/Agency Fax Number: (706) 317-2177 familysupport@nhbh.org

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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 funding for such services/goods and is based on the availability of the Provider Agencies funding for Family Support Services.
_____	Understands 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.
_____	Understands and acknowledges 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.
_____	Understands and attests 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, unless with express prior approval, to the Individual, to the Individual's Family, 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.

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_____ 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 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 receive prior approval 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 recipients of Family Support Services program, as a non-entitlement program and are not eligible to file appeals for services/goods, and or changes to funding.

_____ 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 and cannot change agencies based on funding limits only. Transfers during the fiscal year must be reviewed and approved by the Regional Field Office.

_____ 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.

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Family Support Services Agreements:

The Provider agrees as follows:

1. Provider will develop an Individual Family Support Plan (IFSP) for the Individual/ Applicant. Provider will develop the IFSP in consultation with Individual/ Applicant.
2. Provider will designate a Family Support Coordinator as a single point of contact to work with Individual/Applicant 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/ Applicant and 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 DBHDD review as requested.
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 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/Applicant Signature	Print	Date
Family Member Signature	Print	Date
Family Support Coordinator Signature		Date

DBHDD

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 (optional)

_____ American Indian or Alaskan Native
_____ African American
_____ Multi-Racial/Ethnic Group
_____ Asian or Pacific Islander
_____ Caucasian/Anglo
_____ Other: _____

Ethnicity (optional)

_____ Not Hispanic
_____ Hispanic or Latino

Insurance Information

Private: _____ Public (Medicaid) #: _____

Family member/Guardian Name: _____ _____

Relationship to the Individual:

Legal Guardian of the Individual (Parent of a Minor Child/Guardian of an Adult Individual

Mailing Address: _
Mailing Address: _
City, State, Zip: _
County of Residence: _____
Phone: _____
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: _____

DBHDD

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

_____

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 funded:

_____
_____
_____
_____

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Section V: Agreement Section

I understand to be eligible for the Family Support Program the individual/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.

Individual's Signature (If over 18 years of age) _____ Date _____

Individual's Printed Name _____

Parent/Legal Guardian's Signature (If under the age of 18) _____ Date _____

Parent/Guardian's Printed Name _____

DBHDD

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: New Horizons Behavioral Health - Family Support Services

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: _____