FAMILY SUPPORT PLAN (page 1)

July 2019 thru June 2020

**Identifying Information/Eligible Individual**

First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_

County: Jefferson\_\_ Clear Creek\_\_ Gilpin\_\_ Summit\_\_ Gender: Male\_\_\_ Female\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code\_\_\_\_\_\_\_\_\_

Delay, Diagnosis, or Medical Conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrolled in: Early Intervention\_\_\_\_ Medicaid Waiver (CES, CHCBS, CLLI, SLS, EBD) \_\_\_\_\_\_\_\_ Medicaid insurance\_\_\_ Child Health Plan Plus (CHP+)\_\_\_

**Parent/ Family Contact**

Lives with: Both parents\_\_\_ Mother only\_\_\_ Father only\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Family Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_

Address if different than above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other family members living in the home**

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Age if under 18 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**For office use only:**

Date MIN Assessment received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MIN Assessment Score\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FSSP Priority Level\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FSSP Service Request Form Name of eligible person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What services or supports would you purchase using Family Support funds? Check all that apply.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | FSSP Services |  | FSSP Services |
|  | Respite: temporary care of the family member with a disability to provide relief to the family |  | Medical/Dental Vision: Services necessary to attain or maintain physical health not covered by insurance |
|  | Professional Services: Therapy, counseling, nursing care, may include related support items or activities which are recommended as part of the therapy. |  | Transportation: Direct cost to the family to attend eligible family member’s medical and therapy appointments (travel cost, lodging, food expense) |
|  | Assistive Technology: equipment necessary for the individual with an IDD or developmental delay to communicate, move, manipulate environment, or remain safe in the family home. |  | Other Services: A consultant and/or advocate to assist your family with accessing services outside of the CCB. Family pass to community recreation center, other specialized services. |
|  | Environmental Engineering: Necessary home or vehicle modifications to increase accessibility, independence, or health and safety |  | Parent/Sibling Support: resource materials, cost of care for siblings while addressing the disability needs of the eligible family member, conferences, training, counseling. |

**Describe specific services you want below, how it would be helpful, and the estimated cost.**

|  |  |  |
| --- | --- | --- |
| Item or service requested | Cost of item or service | How is this service or item helpful to your family? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Other Information or Referrals your Resource Coordinator can assist you with. Check all that apply.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Special Needs Trusts, Home Ownership |  | Behavioral or Mental Health Assessment |
|  | Help to make our home more accessible |  | Counseling, parent support group |
|  | How to use our family member’s Medicaid |  | Information about Medicaid Waivers |
| Other information that would be helpful to my family: | | | |

**Print name(s) of person completing the form**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to eligible family member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_