



Enter Eligible Family Member's Name

Children and Family Services  
11177 W 8th Ave., Lakewood, CO 80215  
Voice/TDD 303.233.3363 \* Fax 303.462-6697

To: Families Eligible for the DDRC Family Support Services Program (FSSP)  
From: Susan Johnson, Children and Family Services Director

Re: Funds Available for Disability Related Needs  
Fiscal Year July 1, 2018 through June 30, 2019

This letter explains the process for requesting services through the Family Support Services Program (FSSP) and the Jeffco Children and Family Services Fund (JCFS). If you want to be considered for funds or services, through either of these programs, you must complete a Family Support Most In Need (MIN) Assessment and Family Support Plan.

If your family member's disability-related needs are being met by the Early Intervention program, a Medicaid Waiver program, or an Individualized Education Plan (IEP) you do not need to fill out the MIN Assessment in order to continue those services. Those services are funded separately from FSSP.

### **Family Support Services Program (FSSP)**

FSSP is intended to assist families with costs beyond those typically experienced by other families, to avoid or delay out of home placement, and reduce stress. The program provides funds to address unmet disability related needs, as well as information, support and resource coordination. Families are eligible for FSSP if they have a family member with a developmental delay or disability living in the family home. Families are prioritized for funds based on their MIN Assessment Score unless their family member is enrolled in a Medicaid Waiver program or Early Intervention services. DDRC considers an individual enrolled in CES, SLS, or the EBD Medicaid Waiver as "least in need" regardless of his/her MIN score. Children and adults enrolled in other programs will have their level of need for funds determined on an individual basis. The amount of money approved is based on the services requested and available funds. The average amount of funds approved is \$2000 per eligible individual per year. Some families receive more or less based on their specific service needs. You can request funds for reimbursement of expenses already incurred since 7/1/2018 or for services or items to be purchased prior to 6/30/2019.

### **Jeffco Children and Family Services Fund (JCFS)**

Families who are not prioritized for FSSP funds, based on their MIN score or enrollment in another program, may be eligible for funds through JCFS. Recipients of JCFS must be Jefferson County residents because these funds are from a mill levy on Jeffco property owners. JCFS funds may be available between January and June 2019. The DDRC Board determines the availability and amount of funds for JCFS each year.

### **Most In Need Assessment (MIN) and Family Support Plan (funding request)**

Instructions for completing the MIN Assessment and funding request are on the forms. If there is not enough space in smaller comment boxes use the comment section on the last page of the Family Support Plan. Send the MIN Assessment and the Family Support Plan to DDRC at the address or fax listed above, or email the forms to FSSPMIN@ddrcco.com with Subject Line: FSSP MIN. Your Resource Coordinator will review the information you provide. A visit to your home may be necessary as part of the assessment process. The amount of funds approved is based on your MIN score, the services you request, and supporting documentation.

Funding decisions will be made throughout the year, while funds last. You will be notified in writing when a decision has been made. This may take several months. Families with higher MIN scores are reviewed first. If you have any questions, or would like assistance in completing your MIN Assessment, please contact your Service Coordinator or Resource Coordinator. If you don't know the name of your Coordinator contact our Administrative Assistant at 303.462.6576 or jessica.leon-alvarez@ddrcco.com.

**We must receive your MIN Assessment and Family Support Plan by May 31, 2019**



Developmental Disabilities Resource Center

Quality • Dignity • Choice

Enter Eligible Family Member's Name

## Family Support Most In Need (MIN) Assessment

Name of Individual: \_\_\_\_\_

DOB: \_\_\_\_\_

Form Completed By: \_\_\_\_\_

Age: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

Delay/Diagnosis: \_\_\_\_\_

**Instructions:** In each section below, please check the option that you feel best describes your family member's intellectual/developmental disability (I/DD) or developmental delay. There should be one check mark in the "Needs" area and one in the "Resources" area for each section. The number to the left is the score for each option. Your Resources score subtracted from your Needs score equals your score for that section.

**Please check which resources family members in the home receive, and consider those resources when completing this form:**

<b>Home and Community Based Services Medicaid Waiver</b>		<b>CES</b> <input type="checkbox"/>	<b>SLS</b> <input type="checkbox"/>	<b>EBD</b> <input type="checkbox"/>	<b>CWA</b> <input type="checkbox"/>	<b>CHCBS</b> <input type="checkbox"/>	<b>CLLI</b> <input type="checkbox"/>	<b>BI</b> <input type="checkbox"/>	<b>SCI</b> <input type="checkbox"/>
<input type="checkbox"/>	Private health insurance	<input type="checkbox"/>	Early Intervention (0 thru 2)	<input type="checkbox"/>	Family Income				
<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	WIC	<input type="checkbox"/>	LEAP				
<input type="checkbox"/>	Medicaid Buy-In Program	<input type="checkbox"/>	Home Care Allowance (HCA)	<input type="checkbox"/>	TANF				
<input type="checkbox"/>	Child Health Plan Plus (CHP+)	<input type="checkbox"/>	Quest Card	<input type="checkbox"/>	Section 8 Housing				
<input type="checkbox"/>	SSI	<input type="checkbox"/>	Commodities	<input type="checkbox"/>	Special Needs Trust				

### Mobility

#### Needs

*Consider balance, coordination, amount of assistance needed for mobility/transfers; compare to typical development, consistent with age*

0 <input type="checkbox"/>	Person can walk independently; mobility is not limited, person has full use of hands and feet.
1 <input type="checkbox"/>	Person can walk with some assistance, has use of hands and feet.
2 <input type="checkbox"/>	Limited use of hands and feet; person is unable to walk; person can partially assist with transfers; weight/size is not a problem.
3 <input type="checkbox"/>	Person is unable to walk or move around alone; unable to assist with transfers or weight/size makes transfers difficult.
Comments: _____	

#### Resources

*Consider access to adaptive equipment, therapies, support from others/agencies, funding sources*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments: _____	

### Medical/Nursing Care (Including hearing and vision)

#### Needs

*Compare to typical development*

0 <input type="checkbox"/>	Person does not require any more medical care than routine medical appointments.
2 <input type="checkbox"/>	Person requires more medical care than routine medical visits.
4 <input type="checkbox"/>	Person requires medical care for a frequent and acute illness or medical condition.
6 <input type="checkbox"/>	Person has medical needs that significantly impact their ability to participate in home, school, and community activities.
Comments: _____	

#### Resources

*Consider adequate medical coverage, access to healthcare, etc.*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments: _____	

### Transportation

#### Needs

*Consider: Is the vehicle adequately equipped for the person with the I/DD? Is transportation difficult? Do you spend excessive amounts of time transporting for medical appointments?*

0 <input type="checkbox"/>	Person/family has a typical transportation situation.
1 <input type="checkbox"/>	Person/family's participation in home, school, or community activities is interrupted by access to transportation at least once a week.



Developmental Disabilities Resource Center

Quality • Dignity • Choice

Enter Eligible Family Member's Name

## Family Support Most In Need (MIN) Assessment

2 <input type="checkbox"/>	Person/family's participation in home, school, or community activities is interrupted by access to transportation more than once a week.
3 <input type="checkbox"/>	Person/family has no reliable access to transportation.
Comments:	

### Resources

*Consider ramps, vehicle adaptations, and other persons/agency support*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

## Self-Care (feeding, bathing, dressing, toileting)

### Needs

*Compare to typical development, consistent with age*

0 <input type="checkbox"/>	Person can consistently perform self-care tasks.
1 <input type="checkbox"/>	Person requires verbal reminders to start/complete some tasks.
2 <input type="checkbox"/>	Person requires hands-on assistance to complete most tasks.
3 <input type="checkbox"/>	Person requires total care not consistent with others their age.
Comments:	

### Resources

*Consider availability of support from family members, neighbors, friends, agencies*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet the need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

## Supervision

### Needs

*Compare to typical development, consistent with age*

0 <input type="checkbox"/>	Supervision typical for that age.
2 <input type="checkbox"/>	Person needs occasional supervision.
4 <input type="checkbox"/>	Person requires frequent supervision.
6 <input type="checkbox"/>	Person requires constant supervision (can never be unsupervised)
Comments:	

### Resources

*Consider shared care giving in the home, support by extended family, friends, neighbors, agencies*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

## Behavior

### Needs

*Consider inappropriate behaviors against self, others and/or property, running, wandering, spontaneous crying/screaming; compare to typical development consistent with age*

0 <input type="checkbox"/>	There are no behavioral concerns.
2 <input type="checkbox"/>	There are mild behavioral concerns. May require verbal reminders, redirection or supervision but usually do not result in injury to self, others or property.
4 <input type="checkbox"/>	There are moderate behavioral concerns. Exhibits inappropriate behaviors that put self or others at risk; requires frequent interventions at least weekly.
6 <input type="checkbox"/>	There are extreme behavioral concerns. Exhibits inappropriate behaviors that put self or others at risk; requires frequent interventions at least daily.
Comments:	



Developmental Disabilities Resource Center

Quality • Dignity • Choice

Enter Eligible Family Member's Name

## Family Support Most In Need (MIN) Assessment

### Resources

*Consider breaks from care giving, therapies, support from others/agencies*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

## Sleep

### Needs

*Compare to age-appropriate sleep patterns*

0 <input type="checkbox"/>	There are no sleep problems.
1 <input type="checkbox"/>	There are mild disturbances in sleep patterns that occur approximately once a week.
2 <input type="checkbox"/>	There are moderate disturbances in sleep patterns that occur approximately two to five times a week.
3 <input type="checkbox"/>	There are high disturbances in sleep patterns that require many interventions throughout the night.
Comments:	

### Resources

*Consider shared care giving, breaks from constant supervision, sleep aids/medications, modified sleeping environment*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

## Communication

### Needs

*Compare to typical development, consistent with age*

0 <input type="checkbox"/>	There are no communication concerns.
1 <input type="checkbox"/>	There are mild communication concerns. Can consistently meet needs & wants through limited verbal skills with familiar and unfamiliar people.
2 <input type="checkbox"/>	There are moderate communication concerns. Uses alternative means to communicate such as pointing, PECS, or device; understood only by familiar people.
3 <input type="checkbox"/>	There are extreme communication concerns. Limited or inconsistent ways of communicating with others.
Comments:	

### Resources

*Consider availability of communication devices, sign language, caregivers understanding of personal language/gestures/ expressions*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family member.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	

## Access To Support Networks

### Needs

*Consider level of isolation or lack of support networks for the family*

0 <input type="checkbox"/>	These are not affected by having a person with an I/DD in the home.
1 <input type="checkbox"/>	These are mildly affected by having a person with an I/DD in the home.
2 <input type="checkbox"/>	These are moderately affected by having a person with an I/DD in the home.
3 <input type="checkbox"/>	These are extremely affected by having a person with an I/DD in the home.
Comments:	

### Resources

*Consider shared care giving, support from extended family/friends, church, community organizations, and agencies*

4 <input type="checkbox"/>	No needs in this area. This is not an area of need for our family.
3 <input type="checkbox"/>	Needs are completely met. We are easily able to meet this need with the resources checked above and/or natural supports.
2 <input type="checkbox"/>	Needs are adequately met. We have services or resources in place to address the need. No or low need for FSSP funds.
1 <input type="checkbox"/>	Needs are met/partially met. Cost of services causes some financial stress. We need FSSP funds to help pay for services.
0 <input type="checkbox"/>	Needs are not met. We are unable to meet the need without significant emotional, physical or financial stress. High need for funds.
Comments:	



Developmental Disabilities Resource Center

Quality • Dignity • Choice

Enter Eligible Family Member's Name

Family Support  
Most In Need (MIN) Assessment

**Family Composition & Stability**

Please mark the box that best represents your family/living situation.	N/A	Mild	Moderate	High
	0	1	2	3
Relationships are strained within the family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are other children or adults with disabilities/delays/illnesses in the home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings show signs of stress due to a family member with an I/DD living in the home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our family has responsibility for other extended family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Within the last year there has been a divorce, separation, death, or addition to the family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our family's activities center on the needs of the family member with an I/DD. Caregiver(s) spends excessive time coordinating various needs for family member with I/DD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiver(s) spends excessive time away from job to meet the needs of family member with an I/DD. Caregiver(s) has had to quit their job or is unable to work due to the needs of the family member with an I/DD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are additional difficulties due to the aging/health of caregiver(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiver(s) experiences additional difficulties due to family member with an I/DD being home all day (no school/respite).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other areas of stress on Caregiver(s) not addressed in assessment:				

**I verify that the information stated above is true to the best of my knowledge.**

Completed by

Date

**Contact Information:**

Parent Name	
Parent Address	
County	
Parent Phone Number Daytime phone	

**Return this form by mail, email or fax to:** DDRC/CFS 11177 W. 8<sup>th</sup> Ave. Lakewood, CO 80215

Email: FSSPMIN@ddrcco.com Subject line: FSSP MIN or Fax: 303.462.6697

Families are *eligible* for the Family Support Services Program (FSSP) if they have a family member with a developmental delay or disability living in the family home. The Most In Need (MIN) assessment process determines your family's *level of need* for FSSP per State guidelines. Families are enrolled in FSSP and prioritized for funds based on their total MIN Score, unless their family member is enrolled in a Medicaid Waiver or Early Intervention services. DDRC considers an individual enrolled in CES, SLS, or the EBD Medicaid Waiver as "least in need" regardless of his/her MIN score. Persons enrolled in other programs will have their level of need determined on an individual basis. The amount of funds approved is based on the services requested, supporting documentation, and available funds. If you have questions or need help to complete the form please contact your Resource Coordinator, or the CFS Administrative Assistant at 303.462.6576.

**Admin Use Only Below this line**

Date Received MIN:                      MIN Score:                      MIN Level:                      Low (0-19) Moderate (20-39) High (40+)



Enter Eligible Family Member's Name

*Children and Family Services*  
 11177 W 8th Ave., Lakewood, CO 80215 Voice/  
 TDD 303.233.3363 \* T Fax 303.462.6697

## FAMILY SUPPORT PLAN

### JULY 2018 thru JUNE 2019

RC Name \_\_\_\_\_

#### Section A. Identifying Information

##### Eligible Individual:

First Name:	Middle:	Last:
County: Jefferson <input type="checkbox"/> Gilpin <input type="checkbox"/> Clear Creek <input type="checkbox"/> Summit <input type="checkbox"/>	DOB:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:	City:	Zip code:
Delay/Diagnosis or Medical Condition(s)		
Enrolled in <input type="checkbox"/> EI <input type="checkbox"/> CWA <input type="checkbox"/> CES <input type="checkbox"/> CHCBS <input type="checkbox"/> CLLI <input type="checkbox"/> SLS <input type="checkbox"/> EBD <input type="checkbox"/> SCI <input type="checkbox"/> BI <input type="checkbox"/> CMHS		

##### Parent/Family:

Individual lives with: Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other <input type="checkbox"/>
Primary Language: English <input type="checkbox"/> Spanish/Espanol <input type="checkbox"/> Other: <input type="checkbox"/>

**Primary contact is typically the mother and/or father of the eligible individual, or whomever they live with.**

Primary Contact Name(s)	Phone number _____-_____-_____ home _____-_____-_____ cell
Address:	Relationship:
If different than above	Email address:
Preferred method of contact during day: Phone <input type="checkbox"/> Text <input type="checkbox"/> Work phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/>	

Secondary Contact Name (optional)	Primary phone number _____-_____-_____ home _____-_____-_____ cell
Address:	Relationship:
If different than above	Email address:

**Other family members living in the home: (Use additional page if needed)**

\_\_\_\_\_  
 Name Relationship Age (if under 18)

\_\_\_\_\_  
 Name Relationship Age (if under 18)

**Section B. Resource Coordination Services:** Listed below are some examples of information or referrals your Resource Coordinator could assist you with.

<input type="checkbox"/>	We want information on Special Needs Trusts & Wills and/or Home Ownership programs	<input type="checkbox"/>	We need a behavioral assessment or services (describe below)
<input type="checkbox"/>	We need a home modification assessment (help to make our home more accessible)	<input type="checkbox"/>	We need counseling, or mental health services (describe below)
<input type="checkbox"/>	We want information on how to use our family member's Medicaid insurance (what is covered?)	<input type="checkbox"/>	My child has significant medical or behavioral needs- I want information about Medicaid Waiver programs & other options

**Additional comments or other information that would be helpful to my family**

**Section C. FUNDING REQUEST:** What services or supports would you purchase using Family Support funds? Check  all that apply. Describe the specific services you want below, how it would be helpful and the estimated cost/reimbursement requested.

<input checked="" type="checkbox"/>	<b>FSSP Services</b>	<input checked="" type="checkbox"/>	<b>FSSP Services</b>
<input type="checkbox"/>	<b>Respite Care:</b> temporary care of the family member with a disability that provides relief to the family.	<input type="checkbox"/>	<b>Professional Services:</b> (e.g., therapy, counseling, nursing care, and items/activities recommended as part of therapy).
<input type="checkbox"/>	<b>Medical/Dental/Vision:</b> services necessary to attain or maintain physical health <u>not</u> covered by another source. <b>Excluded:</b> OTC medications and vitamins.	<input type="checkbox"/>	<b>Transportation</b> expenses to specialty medical appointments, therapies, or other disability related appointments not covered by other sources. (Travel costs, lodging, food expense).
<input type="checkbox"/>	<b>Assistive Technology:</b> equipment necessary due to the person's disability to communicate, move through or manipulate their environment (e.g., hearing aids, glasses, wheelchair, communication device).	<input type="checkbox"/>	<b>Other Services:</b> Consultant/Advocate assistance to access services outside the CCB (i.e.; public benefits, guardianship, and IEP meetings). Recreational needs when the cost of the recreation is above and beyond the typical cost.
<input type="checkbox"/>	<b>Environmental Engineering:</b> Necessary home or vehicle modification due to person's disability (i.e.; lifts, ramps, or other adaptations to address health and safety, increase independence and accessibility).	<input type="checkbox"/>	<b>Parent/Sibling Support:</b> Necessary support to assist family to manage additional stress due to providing care for the family member with a developmental disability (e.g., counseling, conferences). <b>Excluded:</b> cost of recreation for family.

Requesting funds for	Cost for service or item	How is this service or item helpful to your family?  I currently pay out of pocket for this service? Yes <input type="checkbox"/> No <input type="checkbox"/> Receipt/bid/bill attached Yes <input type="checkbox"/> No <input type="checkbox"/>
Requesting funds for	Cost for service or item	How is this service or item helpful to your family?  I currently pay out of pocket for this service? Yes <input type="checkbox"/> No <input type="checkbox"/> Receipt/bid/bill attached Yes <input type="checkbox"/> No <input type="checkbox"/>
Requesting funds for	Cost for service or item	How is this service or item helpful to your family?  I currently pay out of pocket for this service? Yes <input type="checkbox"/> No <input type="checkbox"/> Receipt/bid/bill attached Yes <input type="checkbox"/> No <input type="checkbox"/>

What is the total amount of funding you are requesting for FSSP services this year? 7/1/2018 thru 6/30/2019 \$ \_\_\_\_\_

Use additional page if needed

**Section C. SIGNATURE:** A follow-up visit, or call may be necessary as part of the assessment process. You will be notified in writing when a funding decision has been made. The process may take several months due to the large number of families we serve. Call your Resource Coordinator if you have an urgent need.

Print name(s) of person completing form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Enter Eligible Family Member's Name

Children and Family Services \* 11177 West 8th Avenue \* Lakewood, Colorado 80215  
Voice (303) 233-3363 \* Toll Free (800) 649-8815 \* Fax (303) 462-6697

**Additional Comments:**