B&B Care Services, Inc.
Family Support Opportunity

Developmental Disabilities and/or Autism Family Support Services

Funds provided by the Georgia Department of Behavioral Health and Developmental Disabilities are available through B&B Care Services, Inc. for families who care for individuals with Intellectual/Developmental Disabilities and/or Autism.

PURPOSE:

- Keep the family together until the individual with a disability chooses to live independently;
- Enhance a family's ability to meet the many needs of the family member with a disability;
- Improve the quality of supports to families while minimizing the need and cost of out of home placement and to allow families to participate in recreational and social activities;
- Make a positive difference in the life of the person with a disability as well as the lives of all family members.

CRITERIA FOR USE:

- The individual is three (3) years or older with a developmental disability;
- The eligible individual with a developmental disability has the desire to return to or continue home care, or the family with a member who is eligible wishes to return to or continue home care of the individual, but requires support and/or assistance to do so;
- The authorized services and goods for which the individual or family is eligible is sufficient to support and/or assist in the individual's return to home care or the continuation of care in the home setting;
- **Family Support funds are to be the funding of last resort**. Where other programs are also defined as funding of last resort, they are to be used before Family Support funds.
- Children who are 0 – 3 years of age may be served if *Early Intervention: Babies Can't Wait* funding has been exhausted in the region where the family resides.

To apply for this program, please submit a completed application along with required documentation to B&B Care Services, Inc. either by mail, fax, or email.

912-754-0817 ● 855-754-0817

P.O. Box 1040, Springfield, GA 31329 ● FS@BandBCare.com ● Fax 912-754-1534

PARTICIPANT NAME: ________________________________

B&B Care Services, Inc.
Family Support Documentation Checklist

Applicant Name: ___________________________________

Family Caregiver Name: ____________________________

Contact Number: ___________________________________

Contact E-Mail: ____________________________________

B&B Care Services Application and Individual Family Support Plan

Medical Information, Authorization for Emergency Treatment, and Release of Information

Affidavit of Lawful Presence in the United States

DBHDD Family Support Application

DBHDD Individual Family Support Agreement

Birth Certificate

Proof of Guardianship if applicable over the age of 18

Verification of a Disability

B&B Care Services, Inc.
Individualized Family Support Plan

Effective Date: _______________ Expiration Date: _________________

Applicant Name: ____Gender: _______________

Date of Birth: ________________ SSN: ______________________ Medicaid #: ________________________

Address: ____ City: ___________________________

State: ______________________Zip Code: ___________________ County: __________________________

Legal Guardian: ___________________________*(Proof of Guardianship required if Age 18+)* Self Guardian

Family/Caregiver Name: ____Age of Primary Caregiver: _______

Phone Number: *(primary)*________________*(secondary)*__________________*(other)*_____________________

Family/Caregiver/Individual E-Mail:____

Primary Qualifying Diagnosis: ____Age at Diagnosis: _______

Other Diagnoses: ____

Does the applicant wear glasses: Yes No Is the applicant: Ambulatory Verbal Conversational

Race/Ethnicity: African American or Black American Indian or Alaska Native
Pacific Islander or Asian Hispanic or Latino White (not Hispanic) Other Multi-Racial

Height: ___________ Weight: ___________ Hair Color: ___________ Eye Color: ___________

Name of school applicant attends: ____ Grade: _______

Self-Contained Classroom Inclusion General Education Classroom Other _________________________

Barriers, behaviors, or triggers when accessing community: ____

____

____

Other individuals living in your home (excluding applicant):

Name	Age	Relationship to Applicant	Employed?
			☐ FT PT N/A
			☐ FT PT N/A
			☐ FT PT N/A
			☐ FT PT N/A
			☐ FT PT N/A

Number of other family members with a disability: _________ Disabilities:________________________________

Residence:

Own Rent Purchasing Single Family Residence Townhome/Apartment Mobile Home
Brick Vinyl Other Bedrooms _____ Bathrooms _____ Levels _____ Fenced Yard Yes No

Post Office Box 1040 ● Springfield, Georgia 31329 ● 912-754-0817 ● 855-754-0817 ● (Fax) 912-754-1534

B&B Care Services, Inc.
Individualized Family Support Plan

Effective Date: _______________ Expiration Date: _________________

Person Centered Description:

Describe what the individual likes/dislikes:

Describe the individual's skills, or potential skills, and interests:

Describe social identities that are important to the individual and their family:

Describe environments and settings that seem to resonate with the individual:

Describe personal qualities that may be appreciated and enhanced:

Describe personal habits that will shape community participation:

Describe what the individual feels is important in life:
(Include specifics about hobbies, activities, friends, family members, etc.)

Describe what you feel is important for the individual's quality of life:
(Include specifics about health, education, independence, support systems, etc.)

Describe your family's current situation:

Support Network:

Family Friends Church Social Group Coworkers Support Group Other

Describe: ____

B&B Care Services, Inc.
Individualized Family Support Plan

Effective Date: _______________ Expiration Date: _________________

Current Services:

Service/Waiver/Program	Funding Source	Description/Funding Level

Unmet Needs of the Individual:

Unmet Need	Monthly/Annual Cost	Justification of Need

Additional Expenses for the Individual:

Additional Expense	Monthly/Annual Cost	Justification of Need

From the list below, please check the areas your family has identified as needing assistance:
(A budget for Family Support Services shall be established based on available funding and individual family needs.)

Respite Care Community Living Support Community Access Supported Employment Dental Services Medical Care Vision Services Specialized Clothing Specialized Diagnostic Services Recreation/Social Community Integration Activities (SCIA)	Environmental Modifications Specialized Equipment Therapeutic Services Counseling Parent/Family Training Specialized Nutrition Supplies Incontinence Supplies Behavioral Consultation and Support Financial and Life Planning Assistance	Exceptional Disability Related Living Cost Homemaker Services FS Transportation Reimbursement FS Community Integration Transportation Cost Vehicle Adaptation Services Child Day Care/After-School Services Other Family Support Services: ______________________________ ______________________________

Are the goods/services identified above accessible through other sources? Yes No
Have the goods/services identified above been denied through other sources? Yes No
If goods/services have been denied, by which sources? (Include denial information)
☐Group Insurance ☐Medicaid ☐School System ☐Babies Can't Wait ☐Community Action Groups ☐Other: ____

B&B Care Services, Inc.
Individualized Family Support Plan

Effective Date: _______________ Expiration Date: _________________

Please Initial:

_____I hereby confirm that the information given at the time of this plan is true to the best of my knowledge and that any untrue information or misrepresentation will be reported to the state DBHDD Offices and my family may be subject to repayment of all funds utilized on my family's behalf and may be subject to prosecution.

_____I understand that it is my duty to inform B&B Care Services, Inc. of any significant changes in needs or resources immediately and I have the right to participate in plan review at least annually and request changes as needed.

_____I attest that I was informed of my right to participate in the development of this Individualized Family Support Plan, and was given the ability to identify services and goods based on my/our family priority of needs for services/goods.

_____I understand that Family Support Services is a non-entitlement program and B&B Care Services, Inc. may not fund all the services and goods that I may request, and that funding levels can and might change from each funding year and are subject to funding limitations.

_____I understand that each individual may only use one Family Support Agency at a time and that I may not transfer enrollment to another Family Support Agency within one (1) year of beginning services with B&B Care Services, except in case of emergency.

____ _________________________________

Responsible Party Signature **Responsible Party Printed Name**

____ ____________________

Relationship **Date**

____ ____________________

B&B Care Services Representative Signature **Date**

OFFICE USE ONLY: DD Professional - Review of Individualized Family Support Plan		
Signature:	Name:	Date:

Post Office Box 1040 ● Springfield, Georgia 31329 ● 912-754-0817 ● 855-754-0817 ● (Fax) 912-754-1534

B&B Care Services, Inc.
Individualized Respite Plan

Effective Date: _______________ Expiration Date: _________________

Applicant Name: ____Gender: _______________

Date of Birth: ________________ SSN: ______________________ Medicaid #: ________________________

Address: ____ City: ______________________________

State: _______________________Zip Code: ___________________ County: _____________________________

Legal Guardian: ____________________________*(Proof of Guardianship required if Age 18+)* Self Guardian

Family/Caregiver Name: ____Age of Primary Caregiver: _______

Phone Number: *(primary)*________________*(secondary)*__________________*(other)*____________________

Family/Caregiver/Individual E-Mail:____

Primary Qualifying Diagnosis: ____Age at Diagnosis: _______

Other Diagnoses: ____

Does the applicant wear glasses: Yes No Is the applicant: Ambulatory Verbal Conversational

Race/Ethnicity: African American or Black American Indian or Alaska Native
Pacific Islander or Asian Hispanic or Latino White (not Hispanic) Other Multi-Racial

Height: ___________ Weight: ___________ Hair Color: ___________ Eye Color: ___________

Name of school applicant attends: ____ Grade: _______

Self-Contained Classroom Inclusion General Education Classroom Other _________________________

Barriers, behaviors, or triggers when accessing community: ____

____

____

Other individuals living in your home (excluding applicant):

Name	Age	Relationship to Applicant	Employed?
			☐ FT PT N/A
			☐ FT PT N/A
			☐ FT PT N/A
			☐ FT PT N/A
			☐ FT PT N/A

Number of other family members with a disability: _________ Disabilities:_________________________________

Residence:

Own Rent Purchasing Single Family Residence Townhome/Apartment Mobile Home
Brick Vinyl Other Bedrooms _____ Bathrooms _____ Levels _____ Fenced Yard Yes No

B&B Care Services, Inc.
Individualized Respite Plan

Effective Date: _______________ Expiration Date: _________________

Person Centered Description:

Describe what the individual likes/dislikes:

Describe the individual's skills, or potential skills, and interests:

Describe social identities that are important to the individual and their family:

Describe environments and settings that seem to resonate with the individual:

Describe personal qualities that may be appreciated and enhanced:

Describe personal habits that will shape community participation:

Describe what the individual feels is important in life:
(Include specifics about hobbies, activities, friends, family members, etc.)

Describe what you feel is important for the individual's quality of life:
(Include specifics about health, education, independence, support systems, etc.)

Describe your family's current situation:

Support Network:

Family Friends Church Social Group Coworkers Support Group Other

Describe: ____

____

PARTICIPANT NAME: ________________________________ RESPONSIBLE PARTY INITIAL:_____

B&B Care Services, Inc.
Individualized Respite Plan

Effective Date: _______________ Expiration Date: _________________

Current Services:

Service/Waiver/Program	Funding Source	Description/Funding Level

Level of Care:

I. Requires supervision only for safety issues/companionship, assistance with medication, apnea monitoring, no behavior issues.

II. Requires assistance in meeting the five (5) basic needs: Feeding, Bathing, Dressing, Toileting, Transferring, can be total care and/or minor behavioral issues.

III. Medically involved: Tracheotomy suctioning, sterile procedures, any medically invasive care, but not treatment. Excessive behavioral issues: behaviors considered aggressive, self-abusive, or destructive. Behaviors must be considered extensive and a barrier to typical care (excessive biting, hair pulling, hitting, etc.)

Please Initial:

_____I hereby confirm that the information given at the time of this plan is true to the best of my knowledge and that any untrue information or misrepresentation will be reported to the state DBHDD Offices and my family may be subject to repayment of all funds utilized on my family's behalf and may be subject to prosecution.

_____I understand that it is my duty to inform B&B Care Services, Inc. of any significant changes in needs or resources immediately and I have the right to participate in plan review at least annually and request changes as needed.

_____I attest that I was informed of my right to participate in the development of this Individualized Respite Plan, and was given the ability to identify services based on my/our family priority of needs for services.

_____I understand that State Funded Respite is a non-entitlement program and B&B Care Services, Inc. may not fund all the services that I may request, and that funding levels can and might change from each funding year and are subject to funding limitations.

____ **Responsible Party Signature**

____ **Responsible Party Printed Name**

____ **Relationship**

_____________________ **Date**

____ **B&B Care Services Representative Signature**

_____________________ **Date**

OFFICE USE ONLY: DD Professional - Review of Individualized Respite Plan		
Signature:	**Name:**	**Date:**

B&B Care Services, Inc.
Service Agreement

Effective Date: ______________

Individual Name: ____

Date of Birth: _________________ SSN: ___________________ Medicaid #: ___________________

Legal Guardian: ____ Self Guardian

Description of Services: (Please Initial)

_____ **CASE MANAGEMENT:** Those activities normally performed by a Certified Case Manager including, but not limited to, coordination of service delivery, evaluation of participant needs, evaluation and monitoring of services and determining and measuring outcomes.

_____ **FAMILY SUPPORT:** Brokering of goods and services aimed at providing families with the very individualized support they need to continue to care for a family member with disabilities at home. The goal is to prevent crises that can result in the need for out of home placement.

_____ **CONSULTATION:** Include, but not limited to, developing a person centered plan of care, identifying available resources, providing information on the process of accessing services and providing assistance with future planning.

_____ **RESPITE:** A temporary break in the care taking responsibilities of a family member.

_____ **PARENT/FAMILY TRAINING:** Information and/or training provided to parent/family member to enhance the understanding and address the needs of the family member with a disability.

_____ **SUPPORTED EMPLOYMENT:** Supports that enable participants with developmental disabilities to gain and maintain employment in a regular work environment.

_____ **PREVOCATIONAL SERVICES:** Services to prepare individuals for paid/unpaid employment.

_____ **COMMUNITY ACCESS:** Services provided to improve an individual's access to their own community.

_____ **COMMUNITY LIVING SUPPORTS:** Individually tailored supports that assist with the acquisition, retention, or improvement of skills related to the individual continuing to reside in his or her own home or family home.

_____ **ENVIRONMENTAL MODIFICATIONS:** Physical adaptations to the individual's home to ensure health, welfare, and safety or enable greater independence in the home.

_____ **DURABLE MEDICAL EQUIPMENT:** Equipment consisting of devices, controls, appliances, etc. which enable participants to increase their ability to perform activities of daily living.

_____ **MEDICAL SUPPLIES:** Supplies that consist of food supplements, specialized clothing, incontinence supplies, and other authorized supplies.

_____ **SKILLED NURSE SERVICE:** Assessment and treatment of human responses to actual or potential health problems as identified through the nursing process.

B&B Care Services, Inc.
Service Agreement

Effective Date: ______________

Respite and Family Support Voucher Program Waiver and Release: (Please Initial)

_______As a voluntary participant in the B&B Care Services' Respite and/or Family Support Voucher Program, I understand and acknowledge that B&B Care Services is not involved and has not been involved in any way with the selection of the Respite or Family Support provider or agency which will provide goods or services to my family member. I also understand and acknowledge that B&B Care Services makes no representation about the care provider or his/her capability or suitability.

_______I accept that it is my responsibility as a family member or guardian to select provider agencies that will provide goods and services to my family member. I understand that it is my responsibility also to determine the suitability of the provider or agency to provide adequate goods or services to my family member and to acquaint them with the particular needs of my family member. Therefore, on my own behalf and on behalf of my family, I freely and voluntarily accept all risk of personal injury and property damage arising from my family's participation in the program.

_______In consideration of my being allowed to participate in the program and to receive a voucher for services or any purchase of goods or services on behalf of my family, I hereby release and discharge B&B Care Services and its officers, directors, employees, agents and successors, from any and all claims and demands whatsoever that I or my family may hereafter have for injuries or property damage arising or resulting from my and my family's participation in the program, all of which claims I hereby waive. I waive my and my family's right with the full knowledge that B&B Care Services will not compensate me or my family in any way for any losses or injury I or my family may sustain. I understand and agree that this waiver and release will be fully binding on me, all members of my family, our estates, and our heirs, and that neither any member of my family nor anyone claiming through me or any members of my family will have any legal right to assert a claim against B&B Care Services or its officers, directors, employees and agents or any of their successors, relating to me and my family's participation in the program.

Charges and Payments for Services: (Please Initial)

_______**GEORGIA DBHDD FAMILY SUPPORT & RESPITE:** The state has allocated funding to B&B Care Services to assist in providing a variety of goods and services and supports to individuals with disabilities who have the desire to live in their own home.

_______**PRIVATE PAY:** You will be financially responsible for all or part of the cost of services. Payment arrangements must be made prior to service delivery

_______**MEDICAID**

_______**VOCATIONAL REHAB**

_______**OTHER:**____

______________________________	______________________________
Responsible Party Signature	**Responsible Party Printed Name**
______________________________	____________________
Relationship	**Date**
______________________________	____________________
B&B Care Services Representative Signature	**Date**

B&B Care Services, Inc.
Participant's Rights and Responsibilities

Effective Date: ______________

Individual Name: ____

Date of Birth: __________________ SSN: ____________________ Medicaid #: ____________________

Legal Guardian: ____ Self Guardian

B&B Care Services, Inc. is a family centered program that allows families and participants to assist in identifying their need for services and involves families and participants in service design and implementation. B&B Care Services, Inc. does not discriminate because of race, color, sex, creed, religion, age or national origin of the participant, family or provider.

As a participant enrolled in B&B Care Services programs, you and your family have the right to:

1. Not be discriminated against because of race, color, religious creed, disability, handicap, medical condition, ancestry, national origin, age, culture, education, language, socioeconomic status, gender identity, sexual orientation, sex or any protected status.
2. Participate voluntarily in the preparation of service or services to be provided and to receive adequate and appropriate care and services without discrimination and program planning that affects him/her.
3. Participate in the selection of the service delivery team.
4. Receive prompt and confidential services in the least restrictive environment available.
5. Receive person-centered services in conflict free environment.
6. Live and work in a setting integrated into the participant's larger natural community.
7. Access free interpretation services as needed.
8. Be informed of the benefits, risks, and/or side effects of all medications and treatment alternatives.
9. Be free from excessive medication.
10. Be promptly and fully informed in changes in the service plan and to participate in plan development and decision-making regarding the selection, direction, or changes and to receive person-centered services according to the plan.
11. Accept and refuse services.
12. Be fully informed of any charges for services.
13. Not to be neglected, abused, mistreated, or subjected to corporal punishment. To be free of restraints or seclusion, except as a last resort for safety.
14. Not be required to participate in research projects.
15. Manage his or her financial affairs. To keep or have access to participant's own money and personal effects, with limitation to safety. To access training on personal finance effects on Medicaid eligibility.
16. Receive, purchase, have and use personal property, including clothing.
17. Receive or refuse to receive scheduled and unscheduled visitors, communicate, associate, and meet privately with their family and persons of the individual's choice with due regard to Participant's privacy.
18. Reasonable access to a telephone and the opportunity to receive, refuse, and to make private calls with assistance when necessary.
19. Unrestricted mail privileges.
20. Vote if of age and be informed of your right to vote and be assisted in registering and voting.
21. Practice the religion or faith of the your choice. Pursue employment, education, and/or religious expression.

B&B Care Services, Inc.
Participant's Rights and Responsibilities

Effective Date: ______________

22. Not be required to work at home except for the typical upkeep of the individual's bedroom and in the upkeep of family areas and yard.
23. Be treated in such a manner to ensure the individual's safety, health and comfort and the right to be treated as an individual with his or her strengths, unique characteristics and needs acknowledged and respected. The right to have property and residence treated with respect.
24. Maximized amount of time, space and personal privacy in bedrooms, bathrooms, and during personal care consistent with age, level of functioning and delivery of services: the participant has the right to be treated respectfully and to have their property treated with respect.
25. Confidentiality of all information and records and activities within legal limits.
26. Not be subjected to psychological, sexual, fiduciary, mental, or physical humiliation or abuse in any fashion and must be accorded respect and dignity at all times and shall not be exploited or threatened in any way.
27. Prompt and adequate medical treatment when needed.
28. Be informed in a timely manner if impending discharge, continuing care requirements and other available services if needed.
29. Obtain a copy of the provider's most recent completed report of licensure inspection from the provider upon written request.
30. Access to accurate and easy to understand information with sufficient time to make decisions.
31. Choice of approved service provider(s) and team.
32. Be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.
33. Inspect and/or obtain a copy of his or her clinical record and protected health information, to request restriction of the uses and disclosures of his/her PHI, to request alternate means or location of communications or PHI, to correct or amend his/her PHI and to receive an accounting of disclosures of PHI. Receive a separate Notice of Privacy Practices about confidentiality of your PHI.
34. Consult participant's own physician or attorney; filing a complaint.
35. Know the administrator/supervisor of the program. The Administrator, Lynnette Bragg, supervises the program. The business phone number is 912-754-0817 or 800-657-7017. The business address is Post Office Box 1040, Springfield, Georgia 31329.
36. Submit complaints regarding treatment of care that is furnished or not furnished, without fear of discrimination, coercion, reprisal or retaliation to have them investigated within a reasonable period of time.

All complaints may be submitted to the Administrator (Lynnette Bragg) of B&B Care Services at 912-754-0817 or 855-754-0817 or to Post Office Box 1040, Springfield, Georgia 31329. If the complaint is not resolved to your satisfaction, or if you prefer, you may contact the Department of Behavioral Health and Developmental Disabilities Regional Office Monday thru Friday 9 AM to 4 PM, Region 2 (706-792-7733) Region 5 (912-303-1670). Department of Community Health, 2 Peachtree St. NW, 31st Floor, Atlanta, GA 30303 (404-657-5726 or 404-657-5728), Georgia Advocacy Office in Atlanta, 150 E. Ponce de Leon Ave, Suite 430, Decatur, GA 30030 (404-885-1234 or 1-800-537-2329), or Governor's Office of Disability Services Ombudsman, 270 Washington St., 8th Floor, Suite 8087, Atlanta, GA 30334 (404-656-4261 or 1-866-424-7577).

PARTICIPANT NAME: ________________________________ RESPONSIBLE PARTY INITIAL:_____

B&B Care Services, Inc.
Participant's Rights and Responsibilities

Effective Date: ______________

As a participant or family member enrolled in B&B Care Services programs, you and your family have the responsibility to:

1. Provide complete and accurate information to the best of your ability about you or your family member and their specific condition, the home situation and any events that may affect the needed services.
2. Assure that financial obligations are fulfilled as promptly as possible.
3. Be considerate and respectful of your provider and assure a safe work environment.
4. Notify the Agency of any changes in the participant's condition or any events that affect the applicant's service needs within 10 days.
5. Participate actively in decisions regarding individual health care and service/care plan.
6. Comply with agreed-upon care plans.
7. Notify the client's physician, service provider(s), and/or caregivers of any change in one's condition.
8. Be available to provider staff at scheduled times services are to be rendered.

____ ____
Responsible Party Signature **Responsible Party Printed Name**

____ ______________________
Relationship **Date**

____ ______________________
B&B Care Services Representative Signature **Date**

B&B Care Services, Inc.
Health Information & Release

Effective Date: _______________ Expiration Date: _________________

PART I: To be completed by the Legal Guardian or Responsible Party prior to services being rendered

Full Name:			Preferred Name:	Gender:
Address:		City:	County:	Zip:
Height:	Weight:	Primary Phone:	Secondary Phone:	
Age:	DOB:	Race/Ethnicity:	Marital Status:	
Religious Preference:		Legal Status: (Guardian)		
Medicare Number:		Medicaid Number:		
Other Insurance:		Payment Guarantor:		

Primary Physician:	Physician Contact Number:
Physician Address:	
Primary Dentist:	Dentist Contact Number:
Dentist Address:	
Preferred Hospital:	Hospital Contact Number:
Hospital Address:	
Preferred Pharmacy:	Pharmacy Phone
Pharmacy Address:	

Emergency Contacts/Next of Kin (if minor or adjudicated, parent or legal guardian)

Name:		Relationship:	Legal Guardian: Y N
Address:			
Telephone	Home:	Work:	Cell:

Name:		Relationship:	Legal Guardian: Y N
Address:			
Telephone	Home:	Work:	Cell:

Allergies (if *none* specify NKA)

Type of Allergy	**Specific Allergy**
Medication	
Food	
Insect Bites/Stings	
Other Allergies	

All Medical Diagnoses

B&B Care Services, Inc.
Health Information & Release

Effective Date: _______________ Expiration Date: _________________

Chronic and/or Ongoing Medical Issues and Effect on Individual's Life

Current Medication Summary: List all medications currently ordered for the person.

Medication Name	Dosage/Route/ Frequency	Purpose of Medication	Ordered By	Original Date Ordered	Specific Concerns

Describe Assistance Needed to Attain and Take Medication:

Illness/Surgery/Hospitalization	Date	Illness/Surgery/Hospitalization	Date

PARTICIPANT NAME: ________________________________ RESPONSIBLE PARTY INITIAL:_____

B&B Care Services, Inc.
Health Information & Release

Effective Date: _______________ Expiration Date: __________________

Additional Information Which Might Be Pertinent or Helpful to Know for Alternate Caregiver:

(Include behaviors, communication abilities, etc.)

_________________________________ _________________________________

Responsible Party Signature **Responsible Party Printed Name**

_________________________________ _________________________________

Relationship **Date**

+++

Part II: To be completed by the Legal Guardian or Responsible Party

I request and authorize the person providing care to myself or my family member, at my expense, to initiate emergency medical treatment through the designated physician or other recognized medical resource, including 911. When possible, the provider will contact the Legal Guardian or Responsible Party prior to such action unless there is a life-threatening emergency. I also agree to allow the provider to obtain emergency medical transportation at my expense.

I authorize the person providing care to release any and all medical information to the physician or treating facility.

_________________________________ _________________________________

Responsible Party Signature **Responsible Party Printed Name**

_________________________________ _________________________________

Relationship **Date**

_________________________________ _________________________________

B&B Care Services Representative Signature **Date**

B&B Care Services, Inc.
Affidavit of Lawful Presence in the United States

State of Georgia;
County of _______________

Personally appeared before the undersigned officer, duly authorized by law to administer oaths in the State of Georgia, _____________________________ (Applicant's name), who after being duly sworn, deposes and states from his/her own personal knowledge as follows:

I hereby do swear or affirm that I am:

(INITIAL ONE blank below as applicable)

____ a United States citizen or legal permanent resident 18 years of age or older,

OR

____ a qualified alien or non-immigrant under the federal Immigration and Nationality Act lawfully present in the United States, and I am 18 years of age or older.

Further affiant sayeth naught.

____
Signature

____
Printed name

Sworn to and subscribed before me this ____ Day of _________________, 20____.

____
Notary Public

My commission expires: Notary Seal:

____

Individualized Family Support Application

Section I: Demographic Information

Date of Application: ___________________

Individual Name: ____________________________________
Social Security Number: ______________________________
Gender: _______________ Date of Birth: _________________ Age:___________

Race/Ethnicity:
□ American Indian or Alaska Native
□ Black or African American
□ Caucasian/Anglo
□ Other ______________________
□ Asian or Pacific Islander
□ Hispanic or Latino
□ Multi-Racial/Ethnic Group

Insurance Information:
Private: _______________ Medicaid: ____________________ Medicare: ____________________

Family/Caregiver Name: _____________________________________ Age:___________
Relationship to Individual: ___________________________________ □ Legal Guardian of Individual

Mailing Address: _____________________________
Mailing Address: _____________________________
City, State, Zip: _______________________
County: ______________________
Phone: _______________________
Phone: _______________________

Do you want this person to continue living in your home? □ YES □ NO

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)
□ Development Delay (Age 0-8)
□ Traumatic Brain Injury (Prior to age 22)
□ Other: ____

Age at time of diagnosis: _________

Supporting Documentation:

Documentation of Qualifying Diagnosis is required. Please attach a copy of the most recent 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: ____

Section III: Current Service Information

Check all current services that the identified individual is receiving:

□ New Options Waiver (NOW)
□ DBHDD Planning List
□ ICWP
□ CCSP
□ Deeming Waiver (Katie Beckett)
□ Vocational Rehabilitation
□ Food Stamps
□ Individual Education Plan
□ ADRC-Options Counseling
□ Comprehensive Waiver (Comp)
□ SOURCE
□ GAPP
□ DBHDD State Funded Services
□ Child Care Assistance (CAP)
□ Adoption Assistance
□ Other:
□ Other:
□ Other:

Section IV: Services Needs/Requests

Functional Assessment:

Code:

I = Independent
S = Needs Supervision (cues, coaxing, prompting)
T = Total Assistance (performs less that 25% of tasks)
Mod = Moderate Assistance (performs 50%-74% of tasks)
Max = Maximum Assistance (performs 25%-49% of tasks)
Min = Minimum Assistance (performs 75% or more of tasks)

N/A = Not Applicable

Scale	Assessment Area	Explanation/Description:
	Self-Care	(e. Feeding, Grooming, Bathing, Dressing, Toileting, Bladder/Bowel Management, etc.)
	Mobility/Locomotion	(ex. Assistance with transfers, use of wheelchair, crutches, walkers, etc.)
	Communication	(ex. Comprehension, Verbal Expression, Non-Verbal Expression, Speech, etc.)
	Psychosocial	(ex. Social Interaction, Emotional Status, Adjustment to limitations, Employability, etc.)
	Cognitive Functioning	(ex. Problem Solving, Memory, Safety Judgment, etc.)
	Medical/Physical	(Therapy Services (Occupational, Physical, Speech), Medications Seizure Management, Colostomy Care, etc.)
	Behavioral	(ex. Assaultive, Self-Injurious, Behavioral Outbursts, Wandering, etc.)
	Legal	(ex. Criminal Charges, Legal Interaction, Incarceration, etc.)
	Aging	(ex. Dementia, Alzheimer's, Life Planning, etc.)
	Co-Occurring	(ex. Mental/Health Diagnoses or Addiction Diagnosis)

Placement Issues

Are you currently looking for out of home placement? □ YES □ NO

If "Yes," What type of out of home placement? ____

Services/Goods Requested

Please describe the services/goods for which the identified individual needs assistance to continue placement in the family home and/or community:

Describe the benefit to the family if the services and goods above were funded:

Section V: Agreement Section

I understand to be eligible for the Family Support Program the applicant must have a diagnosis of a developmental disability and live in a family member's home or live independently. I hereby confirm that the information given at the time of application is true and accurate to the best of my knowledge.

Responsible Party Signature: ____

Responsible Party Printed Name:_____________________________________

Date: _____________________

Individual/Applicant Family Support Services Acknowledgments:

I, as the Individual/Applicant attest to and agree with the following statements:

(Please Initial)

________The individual with a developmental disability is residing in the home, or the Family Support funds are to be used to prepare the home and the family for the return of the member with a developmental disability from as alternate care placement.

________I understand and acknowledge 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.

________I understand and acknowledge that Family Support is a non-entitlement program, and that determination of eligibility does not guarantee funding of services/goods.

________I understand and acknowledge 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 NOW or COMP Waivers.

________I understand and acknowledge that Family Support services are provided only in the event that such services are not available or cannot be funded through other programs (including, but not limited, to Medicaid, Medicare, charitable organizations, etc.).

________I attest that the family will seek other funding sources for services/goods, when they are identified as payer of services.

________I understand and acknowledge that Family Support Services is a needs based program.

________I understand and acknowledge that that services/goods requested are not available through the Individualized Education Plan (IEP) and protected by the Individuals with Disabilities Education Act (IDEA) and are the responsibility of funding through the Local Education Authority (LEA)

________I understand and acknowledge that no other resources are available for the services the Applicant has requested through Family Support.

________I understand and acknowledge that funding levels may change without prior notification.

________I understand and acknowledge that all funding available through Family Support Services will be used solely for the purpose(s) documented on the Individual Family Support Plan, and to benefit the individual diagnosed with a developmental disability.

________I understand and acknowledge that all services and goods requested must be disability related and for the sole purpose for assisting the family to stay together as a family unit, and the individual to remain in the community setting.

________I understand and acknowledge that only the services/goods listed on the Individual Family Support Plan will be provided at the rate, frequency, duration, and funding limit identified. Any services/goods not listed on the Individual Family Support Plan are not eligible for funding and/or reimbursement.

________I understand and acknowledge that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.

________I understand and acknowledge the continued need for Family Support Services will be re-evaluated no less than annually.

________I understand and acknowledge I must provide supporting documentation for the need of services and goods, including, but not limited to, prescriptions, receipts, etc.

________I understand and acknowledge that I must present receipts or other documentation to verify any expense for which I request payment or reimbursement, and that all requests for reimbursement must comply with Family Support Services Policy. I understand and acknowledge that all direct reimbursement requests must be preauthorized by the provider, and listed on the IFSP. I understand and acknowledge that any misrepresentation 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 applicant and the individual.

________I understand and acknowledge that any misrepresentation of Applicant's/Individual's needs, resources, efforts to obtain services elsewhere, expenses incurred as part of the Family Service Plan and any attempt to misappropriate Family Support funds will result in immediate discontinuation of services, in the lifetime restriction of receiving any future funds/services/goods through Family Support Services, by the applicant and the individual, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s).

________I understand and acknowledge I must provide supporting documentation verifying Family Support Services is the payer of last resort, including, but not limited to, insurance denials, lack of insurance coverage, and verification of lack of funding from community based resources.

________I understand and acknowledge that any individual providing respite services as part of Family Support must be on a region maintain "List of Approved Respite Providers" prior to providing and respite services, and must meet all the requirements for Respite Services Provider, as identified in Family Support Policy. Reimbursement for any services prior to being approved will not be eligible for funding under Family Support Services.

________I understand and acknowledge Family Support funds are not available to reimburse funds already spent by the family, prior to application, and/or that are not specifically listed on the Individual Family Support Plan.

________I understand and acknowledge 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.

________I understand and acknowledge that failure to utilize any funding allocated on the Individualized Family Support Plan will result in the potential for the individual to be placed on a waiting list for funding, until such time as funding becomes available.

________I understand and acknowledge that recipients of Family Support Services, as a non-entitlement program, are not eligible to file grievances for services/goods and/or to changes to funding.

________I understand and acknowledge specific guidelines regarding distribution of funds may vary from agency to agency within the state.

________I understand and acknowledge that families can only receive Family support Services from one Provider/Agency at a time. I agree to only change Provider/Agency with justification regarding services needs and cannot change agencies based on funding limits alone.

________I agree 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 Applicant's and Individual's efforts to obtain service through other programs and regarding Applicant's 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.

Family Support Services Agreements:

The Provider agrees as follows:

1. The Provider will develop an Individual Family Support Plan (IFSP) for Applicant and Individual. Provider will develop the IFSP in consultation with Applicant and to the extent possible, with the Individual.
2. The Provider will designate a Family Support Coordinator as a single point of contact to work with Applicant and Individual in obtaining Family Support.
3. The Provider will review the IFSP annually, and at such time as there has been a significant change in Applicant's/ Individual's resources or needs.
4. The Provider will inform Applicant in writing of Applicant's rights to participate in the IFSP and IFSP reviews, and to appeal a denial, discontinuance, or reduction in benefits.

Both parties agree as follows:

1. The Provider and Applicant will sign both copies of this agreement and return one signed copy to the appropriate DBHDD Regional Office. The Provider for State Review will keep a copy on file, as needed.
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 is true and accurate 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	Date
______________________________	______________________________
Provider/Agency Signature	Date
______________________________	______________________________
Provider/Agency Printed Name	Title

B&B Care Services, Inc.
Family Support Authorized Goods and Services

The following is a list of goods and services that may be purchased with Family Support funds either by a contracted provider or directly for a family depending on funding availability and approval of B&B Care Services, Inc. Family Support Coordinator or CEO.

Family Support Respite Care - A service designed to relieve a family/care giver of physical or emotional stresses associated with the care of the member with a developmental disability by the provision of temporary care of the member with a developmental disability in or out of the home.

Family Support Community Living Support - An array of services to assist an individual with the developmental disability to perform activities of daily living.

Family Support Community Access - An array of services that support an individual with a developmental disability in being involved in their community, based on his/her needs, wants and preferences.

Family Support Supported Employment - Services to support individuals to become gainfully employed and to maintain their employment in the community.

Dental Services - The full array of services designed to care for the teeth, oral cavity and maxillofacial area, provided by or under the direct supervision of a licensed dentist.

Medical Care - Services provided by or under the direct supervision of a licensed physician or by other licensed or certified health care professionals, when ordered by a licensed physician.

Specialized Clothing - Services that include the assessment of need, design, construction, fitting and cost of an article of clothing, which is necessitated by the handicapping condition of the individual with the developmental disability.

Specialized Diagnostic Services - Specific investigative procedures determined as needed by the family and inter-disciplinary team are necessary to complete the assessment of needs of the individual with disabilities and/or family.

Recreation/Social Community Integration Activities - Activities and or goods designed to support the participation of the individual with a developmental disability in recreational/social community integration activities in the home and/or community.

Family Support Environmental Modifications - Changes, or repairs to the personal home of the family/caregiver that are designed to increase their ability to enhance the development/functioning, health or well being of the individual with a developmental disability.

PARTICIPANT NAME: ________________________________

B&B Care Services, Inc.
Family Support Authorized Goods and Services

Family Support Specialized Equipment - Adaptive and therapeutic devices specifically prescribed to meet the facilitative needs of the individual with a developmental disability or devices and equipment needed by the family to better provide for the specific needs of the family member with a developmental disability.

Therapeutic Services - A direct intervention service provided by a licensed therapist aimed at reducing or eliminating physical manifestations of a developmental disability or in improving/acquiring specific skills precluded by the developmental disability.

Counseling - Services utilizing a varied number of specific psychosocial approaches, by a licensed counselor for the individual with a developmental disability and/or his/her family.

Parent/Family Training - Information and training for parents/family members to enhance understanding and to better address the needs of the family member who has a developmental disability.

Specialized Nutrition - An array of services that include: assessment, planning, counseling, supervision and provision of specific dietary, nutritional and feeding needs of the individual with a developmental disability.

Supplies/Incontinence Supplies - Any number of items that may require frequent usage due to the individual's developmental disability. These supplies may not be specialized or specific to the needs of the individual with the developmental disability, but may be necessary to the on-going operation or maintenance of specialized devices or any number of items that are needed by the family, to better provide for the disability specific needs of the family member with the developmental disability.

Behavioral Consultation and Support - Professional services which train and support the family in avoiding and/or responding appropriately to behaviors which may create barriers to the individual with a developmental disability and their ability to remain in the home and community.

Financial and Life Planning Assistance - Professional services which assist the family in planning for future services and/or financial needs of the family member with a developmental disability.

Family Support Transportation – Travel and travel related costs (including subsistence costs) associated with the receipt of a service identified in the plan, and documented by the provider to be necessary to meet the needs of the family.

PARTICIPANT NAME: ________________________________