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

Family Support Documentation Checklist

Applicant Name: _____

Family Caregiver Name: _____

Contact Number: _____

Contact E-Mail: _____

- ☐ B&B Care Services Application and Individualized Family Support and Respite Plan
- ☐ Medical Information, Authorization of Emergency Treatment, and Release of Information
- ☐ DBHDD Family Support Application
- ☐ DBHDD Individual Family Support Agreement
- ☐ Consent for Release/Receipt of Information
- ☐ Affidavit of Lawful Presence in the United States, if applicable over the age of 18*
- ☐ 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:_____ Primary Contact Name:_____
Phone:_____Email:_____

Applicant Name:_____ Gender:_____

Date of Birth:_____ SSN:_____ Medicaid #:_____

Address:_____ City:_____ State:_____

Zip Code:_____ County:_____ Region:_____ Program:_____

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: _____

Race/Ethnicity:

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

Eligibility Criteria:

☐ Intellectual/Developmental
☐ 3 Years or Older
☐ Autism
☐ Desire to Continue in Family Home
☐ Currently Residing in a Family Unit

Other individuals living in your home (excluding applicant):

Name	Birthdate	Relationship to Applicant	Employed?
			☐ FT ☐ PT ☐ N/A
			☐ 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:_____

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Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Education:

Name of school applicant attends: _____ Grade:_____

☐ Self-Contained ☐ Inclusion ☐ General Education ☐ Homeschool ☐ Other

Physical Description:

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Does the applicant wear glasses: ☐ Yes ☐ No

Is the applicant:

☐ Ambulatory ☐ Verbal ☐ Non-Verbal ☐ Non-Conversational

Person-Centered Description of Individual:

(Give a brief description of the individual requesting services. Include likes, dislikes, skills, interests, and behaviors.)

Describe what the individual feels is important in life:

(Include specific hobbies, activities, friends, family members, etc.)

Support Network:

☐ Family ☐ Friends ☐ Church
☐ Social Group ☐ Coworkers ☐ Support Group
☐ Other

Describe:

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Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Describe what you feel is important for the individual's quality of life:

Describe your family's current situation:
(Please include details of your physical environment, neighborhood, caregiver employment, and any other pertinent information that describes your family's current situation.)

Residence:

☐ Own	☐ Brick	☐ Single Family Residence
☐ Rent	☐ Vinyl	☐ Townhome/Apartment
☐ Purchasing	☐ Other	☐ Mobile Home

Bedrooms:_____ Bathrooms:_____ Levels:_____ Fenced Yard: ☐ Yes ☐ No

B&B Care Services, Inc.
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Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Current Service Information

- ❑ New Options Waiver (NOW)
- ❑ DBHDD Planning List
- ❑ ICWP
- ❑ EDWP
- ❑ Deeming Waiver (Katie Beckett)
- ❑ Vocational Rehabilitation
- ❑ Food Stamps (Amount received monthly)
- ❑ Individual Education Plan
- ❑ ADRC- Options Counseling
- ❑ Comprehensive Waiver (COMP)
- ❑ SOURCE
- ❑ GAPP (Number of hours used monthly)
- ❑ DBHDD State Funded Services
- ❑ Child Care Assistance (CAP)
- ❑ Adoption Assistance
- ❑ SSDI/Survivor's Benefits, SSI (Amount received monthly)
- ❑ Easter Seals CHAMPIONS
- ❑ Other (Please specify)

Current Services: (Use the list above to identify all current services the individual is receiving.)

Service/Waiver/Program	Funding Source	Description/Funding Level

Is the individual currently on the Planning List? ☐ Yes ☐ No

If so, who is the Planning List Administrator? _____

Was the individual denied the NOW/COMP Waiver? ☐ Yes ☐ No

If so, why? _____

Unmet Needs of the Individual: (Services/goods needed related to the individual's diagnosis needing financial assistance.)

Unmet Need	Monthly/Annual Cost	Justification of Need

Additional Expenses for the Individual: (Services/goods paid out of pocket for due to the individual's diagnosis.)

Additional Expense	Monthly/Annual Cost	Justification of Need

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Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

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/caregiver 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 individual 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.

Vision Care- A service designed to care for the eyes. Services are provided under the direct supervision of a licensed optometrist or ophthalmologist, which are not covered under any vision insurance public and/or private.

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 developmental disability.

Specialized Diagnostic Services- Specific investigative procedures determined as needed by the family and interdisciplinary 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 recreation/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.

Family Support Specialized Equipment- Adaptive and therapeutic devices specifically prescriped 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 the future services and/or financial needs of the family member with a developmental disability.

Exceptional Disability Related Living Cost- This service is utilized to pay living expenses that are higher than normal due to the nature of the individual's 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.

Vehicle Adaptation Services- These services include adaptations to the individual's or family's vehicle in order to accommodate the special needs of the individual with a developmental disability.

Child Day Care/After School Services- These services are specific to after-school programs or child day care costs at a licensed child care facility or a family's share of such costs for the individual with the disability.

Other Family Support Services- If a service or item does not fit the categories list, the provider submits a request for Other Family Support Services Funding Form with justification and supporting documentation for prior approval from the Regional Services Administrator for Developmental Disabilities or their designee prior to approving and/or providing the service for the individual and/or family.

B&B Care Services, Inc.
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Effective Date: 07/01/2020 Expiration Date: 06/30/2021
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Services/Goods Requested

DBHDD's Family Support Program is a non-entitlement program based on funding availability and level of need. The annual maximum allowance is **UP** to $3,000.00 per fiscal year. DBHDD makes it very clear that no individual and/or family is guaranteed that amount of funing. Individual's request who are currently on the NOW/COMP Planning List will take priority over all others. Requests are to be submitted to **fs@bandbcare.com** between the 1st and 15th of each month for services/goods needed for the following month. Caregiver is notified on or about the 25th of the month as to whether their request are approved.

1. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
2. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
3. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
4. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
5. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____
6. Service/Good: _____ Category: _____ Amount: _____
   Measurable Goal: _____
   _____

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Please Initial:

_____I understand in consideration of my being allowed to participate in the program, I must obtain a voucher form from B&B Care Services, Inc. for services or any purchase of goods or services on behalf of my family.

_____I hereby confirm that the information give 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 and/or Respite Plan, and was give the ability to identify services and goods based on my/our family priority of needs for services/goods.

_____I understand that Family Support is a non-entitlement program, may not fund all services and goods that are requested, and 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 (1) 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, Inc. except in case of emergency.

_____ _____
Responsible Party Signature **Responsible Party Printed Name**

_____ _____
Relationship **Date**

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

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Service Agreement

Description of Services (Please Initial)

FAMILY SUPPORT:

____ **FAMILY SUPPORT COORDINATION:** Services to support the individual and family in multiple facets of life by linking them to needed services and resources.

____ **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.

____ **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.

OTHER:

____ **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.

____ **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.

____ **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.

CHARGES AND PAYMENTS FOR SERVICES:

____ **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:**_____

PARTICIPANT NAME:_____ RESPONSIBLE PARTY INITIAL:____

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

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 an 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 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 reevaluated 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 request 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.

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Individualized Family Support Plan

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

____ 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 receiving 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 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 members. 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 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, related to me and my family's participation in the program.

_____ _____
Responsible Party Signature **Responsible Party Printed Name**

_____ _____
Relationship **Date**

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

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Participant's Rights and Responsibilities

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 Medicaideligibility.
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.
22. 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.
23. 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
24. Confidentiality of all information and records and activities within legal limits.
25. 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.
26. Prompt and adequate medical treatment when needed.

PARTICIPANT NAME:_____ RESPONSIBLE PARTY INITIAL:_____

27. Be informed in a timely manner if impending discharge, continuing care requirements and other available services if needed.
28. Obtain a copy of the provider's most recent completed report of licensure inspection and/or accreditation from the provider upon written request.
29. Access to accurate and easy to understand information with sufficient time to make decisions.
30. Choice of approved service provider(s) and team.
31. Be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.
32. 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.
33. Consult participant's own physician or attorney; filing a complaint.
34. Know the administrator/supervisor of the program. The Administrator, Lynnette Bragg, supervises the program. The business phone number is 912-754-0817 or 800-754-0817. The business address is Post Office Box 1040, Springfield, Georgia 31329.
35. 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 (Dean Beasley) 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 5 PM, Region 2 (706-732-7733) Region 5 (912-303-1670). Department of Community Health, 2 Peachtree St. NW, 31st Floor, Atlanta, 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).

As a participant of 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**

OFFICE USE ONLY: DD Professional – Review of Individual Family Support Plan		
Signature:	**Name:**	**Date:**

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

STATE FUNDED RESPITE

B&B Care Services, Inc. has received a contract from the State of Georgia, Department of Behavioral Health and Developmental Disabilities for the Fiscal Year beginning July 1, 2020 for the purpose of procuring respite services for families who provide supports to individuals with Developmental Disabilities who are:

- currently living with the family; and,
- the family desires for the individual to continue living with the family.
- The purpose of respite service is to provide temporary relief of the caregiving responsibilities.

The State Funded Respite funding is separate from, and in addition to, the Family Support category that also includes respite as a category. The state has increased the maximum number of hours reimbursed per day from six to seven and one half (7.5) hours per day. Please note, that regardless of the number of hours used up to the 7.5 hours, any time used on that date will count as one day. The State has allowed for a daily rate in the event over 7.5 hours are necessary or desired.

State Funded Respite may provide up to a maximum of 30 days per fiscal year (July 1 - June 30th), based on funding availability. Utilization of this service is by Region Approval ONLY.

Caregivers have the responsibility for selecting, training, and supervising the qualified agency selected to be the respite provider on the specific needs of the individual to receive service. Qualified providers are only those agencies that are approved by the Department of Behavioral Health and Developmental Disabilities and carry the required Department of Community Health, Office of Regulatory Services license to provide either in home supports our Alternative Living Supports. B&B Care Services must obtain agreements with these agencies prior to the issuing of prior authorizations.

State Funded Respite Scheduling:

- Email: Email fs@bandbcare.com with your request for the next month by the 15thth of the month before you are requesting respite. If approved, B&B staff will email you and your chosen provider a Prior Authorization (Voucher) that will confirm the date and hours authorized. YOU MUST HAVE THIS PRIOR AUTHORIZATION IN HAND BEFORE THE RESPITE SERVICE OCCURS OR YOU WILL BE RESPONSIBLE FOR PAYMENT TO THE PROVIDER.
- Telephone: Contact the office by phone prior to the 15th and ask to speak with the Respite Coordinator to request Respite Services. The Respite Coordinator will mail you and your chosen provider a Prior Authorization (Voucher) that will confirm the date and hours authorized. YOU MUST HAVE THIS PRIOR AUTHORIZATION IN HAND BEFORE THE RESPITE SERVICE OCCURS OR YOU WILL BE RESPONSIBLE FOR PAYMENT TO THE PROVIDER.
- All Respite Services scheduled directly with the provider without a Prior Authorization will be the financial responsibility of the Legal Guardian or parent.
- The caregiver has the responsibility for scheduling the respite service with the provider agency once the prior authorization is issued.

The provider will confirm, after Respite is provided, that the service was utilized and B&B Care Services will submit the expense for reimbursement.

If you have any further questions please feel free to contact our office via email at respite@bandbcare.com or by telephone at

(912) 754-0817 or (855) 754-0817.

Thank you for the opportunity to work with you and your family.

PARTICIPANT NAME:_____ RESPONSIBLE PARTY INITIAL: _____

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Health Information & Release

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

Preferred Name:	Gender:	DOB:	Age:
Address:	City:	County:	Zip:
Height:	Weight:	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
Address:			
Telephone	Home:	Work:	Cell:

Name:	Relationship:		☐ Legal Guardian
Address:			
Telephone	Home:	Work:	Cell:

Allergies (if none specify NKA)

Type of Allergy	Specify Allergy
Medication	
Food	
Insect Bites/Stings	
Other Allergies	

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

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Functional Assessment:

Code:
I = Independent
S = Needs Supervision (Cues, Coaxing, Prompting)
T = Total Assistance (Performs less than 25% of tasks)
N/A= Not Applicable
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)

Scale	Assessment Area	Description
	Self-Care	(Ex: 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 Judgement, etc.)
	Medical/ Physical	(Ex: 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 Diagnosis or Addiction Diagnosis)

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

(Include behaviors, communication abilities, etc.)

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

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 Caregiver Assistance Needed to Attain and Take Medication: (Check all that apply)

- ☐ Obtains Prescriptions and Refills
- ☐ Administers Medications
- ☐ Monitors for Side Effects
- ☐ Independent
- ☐ Needs Reminders
- ☐ Uses Pill Organizer, Alarm, etc. Please Specify: _____

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

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

Effective Date:_____ Expiration Date:_____
Applicant Name:_____ Primary Contact Name:_____
Phone:_____Email:_____

Level of Care: (Check the level that describes individual)

- ☐ I. Mild support need and requires little to no support for medical or behavioral conditions.
- ☐ II. Modest-to-moderate support needs and requires little to no support for medical or behavioral conditions.
- ☐ III. Little to moderate support needs and requires significant support due to medical or behavioral conditions.
- ☐ IV. Moderate-to-high support needs and requires more frequent supports that may include physical assistance in several daily life activities.
- ☐ V. Most significant support needs and requires frequent physical assistance in numerous daily life activities.
- ☐ VI. Exceptional medical conditions and requires enhanced supports.
- ☐ VII. Exceptional behavioral challenges and requires enhanced supports.

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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**

CONSENT FOR RELEASE/RECEIPT OF INFORMATION

Participant Name: _____

Address: _____

I hereby authorize B&B Care Services, Inc. to release and/or obtain any or all information needed to provide the supports and services requested including, but not limited to, health protected information.

I understand that the purpose of this consent has been explained to my satisfaction and I understand its contents.

Yes_____ No_____
Initial **Initial**

This consent is valid for (1) year and I understand that I can withdraw this consent at any time except to the extent that action has been taken.

_____ _____
Responsible Party Signature **Responsible Party Printed Name**

_____ _____
Relationship **Date**

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

Affidavit of Lawful Presence in the United States

State of Georgia;
County of _____

Personally appeared before the undersigned office, 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 and 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:
_____