Dear Family,

Enclosed please find an application for Autism or DD Family Support/Ease Funding. Please look it over and fill it out as soon as you get a chance. There are several things that we require to process your application. You must have:

* Completed Family Ease Application includes: Application, Financial Statement, **Proof of Income is REQUIRED**, Request Form, Family Ease Agreement, **PLEASE READ CAREFULLY**, and Authorization for release of Information. THE ENTIRE APPLICATION MUST BE FILLED OUT COMPLETELY!
* Signature Required on Application
* Documentation of Income (SSI statement, W-2, or copy of Pay Stub-Current Information IS REQUIRED)
* Documentation of Developmental Disability (IEP, letter from Physician, Psychological evaluation)
* Documentation from a Professional (Physician, Therapist, Doctor) stating the needs for goods/services (Letter of Recommendation)
* Documentation showing that (canceled checks or receipts) you have paid for or are being billed for the requested items or services, along with Documentation from a Professional (Letter of Recommendation). If you have not yet purchased items or services, a letter from the provider or merchandiser stating costs including shipping and handling is required; along with a provider application from Georgia Community Support and Solutions is required for the provider you will be receiving items or services from.
* For Autism, the family must live in Gwinnett, Rockdale, Newton, Dekalb, Fulton, Cobb or Douglas Counties.
* For DD, the family must live in Gwinnett, Rockdale, Newton, Dekalb, Cobb or Douglas Counties.

It will be more important than ever to ensure that all required documents are returned with the application and that the request for support is comprehensive and precise. Please note, also, that each family is responsible for a portion based on a sliding scale.

Also included is a family information packet that explains the program further. This is for you to keep for your reference.

Thanks for your interest in our Program. We look forward to working with you.

The Family Ease Department
404-634-4222, Ext. 365

GEORGIA COMMUNITY SUPPORT & SOLUTIONS

FAMILY EASE APPLICATION

For Autism and Developmental Disability (DD) Programs
Please Circle Which Program (Circle One): Autism DD
(Autism is for participants who have diagnoses of Autism, PDD, or Asperger's)

Date_____

Participant Information

Name: _____

Social Security Number:
_____

Birth Date: _____

Address: _____
Street Address Apt. #

_____
City State Zip Code

County (please circle one): GWINNETT ROCKDALE NEWTON COBB
DEKALB FULTON DOUGLAS

Disabilities: **Primary/Secondary Diagnosis** (Please list what is on the Documentation of Developmental Disability (IEP with Primary Diagnosis, letter from Physician, Psychological evaluation) :

_____

_____

Please give a brief description of the participant's condition and special needs:

_____

_____

Relationship to participant:_____.

Legal Status of Participant:
MINOR COMPETENTADULT INCOMPETENTADULT
(Must Provide a Court Order)

For Program Evaluation Purposes (Please Circle One For Each):

RACE: African-American Asian Pacific Islander Caucasian

Hispanic Native American Mixed Other

SEX: Male Female

Hair Color: Black Brown Blonde Red White
Other

Eye Color: Black Brown Green Hazel
Gray Blue

Height_____ Weight_____

Responsible Party Information

Primary Caregiver

Name: _____

Social Security Number: _____

Address:
If different from Participant's address

_____

_____

Birth Date:
_____

Marital Status (Please Circle One): Single Married Divorced Widowed
Separated Sharing household with committed partner

Occupation:
_____

Employer:
_____
Home Number ( )_____ Pager( )_____
Work Number( )_____ Email:_____
Cell Number( )_____

Other Responsible Party Information

Name: _____

Social Security Number: _____

Address:
If Different from Participant/ Primary Caregiver

_____

_____

Birth Date:
_____

Occupation:
_____

Employer:_____

Home Number ( )_____
Work( )_____
Car Phone ( ) _____
Pager( )_____
Email Address_____

Participant Information

Medicaid number _____

Private Insurance**:** Yes/No. If yes, Name of Company: _____

Group # _____ Policy # _____

Name of Insured: _____

Please list other services or supports your family has used (in the past 12 months):

_____

_____

_____

Has the participant applied for a waiver? Yes or No. If yes, Is the participant on the long or short term planning list? _____.

Does the participant currently have a Waiver? (Example: Medicaid Waiver, Community Care Waiver (CCSP), Georgia Pediatric Waiver (GAPP), Katie Beckett. Yes or No If yes, what type?

_____

Has the participant received Autism or DD Funding in the past? Yes or No
What Year (s)? _____

Please List any other children/family members with a developmental disability in the household: Please include what type of developmental disability.

_____
_____
_____

What are your family's strengths (positive things about your family)?

_____

_____

Please describe the natural supports in your family has available (extended family members, faith communities, or community resources, etc)

_____

_____

Are there other stress factors that we should be aware of (illness of primary care giver, unstable living situations, excessive behavioral or medical needs of person with disability or other family members)?

_____

_____

_____

How would family ease funding make a significant difference to the well being of your family?

_____

_____

Documentation from a Professional (Physician, Therapist, Doctor) stating the needs for goods/services (Letter of Recommendation) is required with this section. Please give a description of the services or items requested:

_____

_____

_____

Please give the approximate cost of your request: _____

How were you referred to the Family Ease Program?

Referral Name: _____ _____

Phone: ( )_____

I hereby confirm that the information given at the time of application is true to the best of my knowledge.

Signature of Parent/Guardian:_____

Parent/Guardian Name (Print):_____

Relationship to Participant:_____

Other Parent/Guardian:_____

Parent/Guardian Name (Print):_____

Relationship to Participant:_____

Applicant Signature:_____

Participant Name (Print):_____

Questions and Concerns please contact: Family Ease Department
(404) 634-4222 ext. 365
Georgia Community Support and Solutions
1945 Cliff Valley Way, Ste 220
Atlanta, GA 30329

AUTISM/DD FAMILY EASE
Financial Statement

It is very important that you include Documentation of Income (SSI statement, W-2, or copy of most recent Pay Stub) * All Current Information is Required.

I, _____ acknowledge that my
(Your name)

Annual net family income is _____.
(**Failure to fill in will delay application process**)

I understand that this information will be used as part of the needs assessment and sliding scale for my family.

Please attach a copy of **one** of the following for **all** primary caregivers if your child or family member is **under** the age of 18.

_____ Most recent tax return indicating net annual income

_____ Most recent pay stub for **each** primary caregiver

Please check here if the participant is over the age of 18 _____. If your child or family member is over the age of 18, please include a copy of social security income documentation.

Please check the number of family members currently living in your home:

_____ **2 or less** _____ **3** _____ **4** _____ **5 or more**

_____
Signature of Parent/Guardian/Primary Caretaker

_____
Printed Name of Parent/Guardian/Primary Caretaker

_____
Date

_____ _____
Printed Name of Participant Date of Birth

PLEASE READ CAREFULLY
Family Ease Agreement- MHDDAD Region 3
Gwinnett, Rockdale, Newton, Fulton, Douglas, Cobb, DeKalb

_____("Applicant") has submitted an application on behalf of the family of _____("Participant/Consumer") for Family Ease services, and Georgia Community Support and Solutions, Inc, ("Provider"), a Family Ease Provider contracting with Metro MHDDAD Region, has agreed to provide certain services. This is an agreement between the Applicant, on behalf of the Consumer and his/her family (as defined in the Family Ease Operating Procedures). The family is eligible only if the member with disabilities is residing in the home, or if the Family Ease funds are to be used to prepare the home and family for the return of the member with disabilities form an alternate care placement, and Provider regarding Family Ease Services.

Applicant agrees as follows:

1. Applicant understands and acknowledges that Family Ease 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.)
2. Applicant has provided complete and accurate information to Provider regarding Applicant's and Consumer's efforts to obtain services through other programs, and regarding Applicant's and Consumer's financial and other resources and needs. Applicant represents that no other resources are available for the services Applicant has requested as Family Ease.
3. Applicant represents that all money received through Family Ease services will be used solely for the purpose(s) documented on the Applicant's Individual Family Ease Plan. The Applicant understands and acknowledges that Family Ease funds cannot be advanced to the Applicant or to any provider of services under any circumstances.
4. Applicant understands and acknowledges that he/she must present receipts or other documentation to verify any expense for which he/she requests payment or reimbursement. Any misrepresentation of expenses or other attempt to misappropriate these funds is strictly prohibited and subject to legal action.
5. Applicant understands and acknowledges that any misrepresentation of Applicant's/Consumer's needs, resources, efforts to obtain services elsewhere, expenses incurred as part of the Family Ease Plan, and any attempt to misappropriate Family Ease funds will result in immediate discontinuation of services, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) and misappropriation(s).
6. Applicant understands and acknowledges that any individual providing respite services as part of Family Ease must be on a region maintained "Registry of Approved Respite Providers" **PRIOR** to providing any respite services. (They

cannot be reimbursed for any services provider prior to being placed on the registry.) In order to be placed on the registry, respite service providers must provide the region with proof of certification in Cardiopulmonary Resuscitation (CPR) and documentation has to be received by the region that the applicant has satisfactory passed a criminal records background check.

7. Applicant understands and acknowledges that Family Ease 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 Consumer to live at home in the community. The continued need for Family Ease services will be re-evaluated no less than every 6-month.
8. Applicant agrees to use the Family Ease services in compliance with all applicable guidelines.

Provider Agrees as follows:

1. Provider will develop an Individual Family Support Plan (IFSP) for Applicant and Consumer. Provider will develop the IFSP in consultation with Applicant and, to the extent possible, with Consumer.
2. Provider will set fees to Family Support goods and services on a "sliding fee" basis in consideration of Applicant's resources, ad in compliance with applicable DHR fiscal ruled and regulations.
3. Provider will designate a Family Ease Coordinator as a single point of contact to work with the Applicant and Consumer in obtaining Family Support.
4. Provider will review IFSP every six (6) months, and at such time as there has been a significant change in Applicant's/Consumer's resources or needs.
5. Provider will inform Applicant in writing of Applicant's rights to participate in the IFSP or IFSP reviews, and to appeal a denial, discontinuation, or reduction in benefits.

Both Parties agree as follows:

1. Provider and Applicant will sign both copies of this agreement and return one signed copy to Metro MHDDAD Regional Office.
2. This Agreement contains the entire agreement of the parties and there are no other promises or conditions in other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the 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 will terminate upon written notice of either party.

Printed Name of Participant/Consumer

Printed Name of Applicant Relationship to Participant/Consumer

Signature of Applicant Date

Applicant's Address

Georgia Community Support & Solutions, Inc
Provider Agency

Whitney Fuchs, Executive Director
Name and Title of Provider Official

Provider Signature Date

Georgia Community Support & Solutions, Inc
1945 Cliff Valley Way, Suite 220
Atlanta, Ga. 30329

AUTISM/DD FAMILY EASE

Participants Name: _____

Date of Birth: _____ Soc. Sec # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize: - Georgia Community Support and Solutions
1945 Cliff Valley Way, Suite 220
Atlanta, GA 30329

To release the following types of information from my family's Autism Family Ease application:

_____

_____

For the purpose of: -_____

_____

Disclosure will be by the following method(s): (check all applicable)

Fax ___ Written ___ Verbal___ Electronic___Audio Tapes___ Video Tapes___Photo ___

All information I hereby authorize to be released from this agency will be held strictly confidential. I understand that this authorization will remain in effort for:

____Ninety (90) days unless I specify an earlier expiration date here: _____
____One (1) year.

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my family's consent, I may withdraw this consent at any time.

_____
(Signature of Participant) Date

_____
(Signature of Parent or Guardian) Date

_____
(Signature of Witness) Date

USE THIS SPACE ONLY IF PARTICIPANT/PARENT/GUARDIAN WITHDRAWS CONSENT

_____
(Signature of Person/Parent/Guardian) (Date this consent is revoked)

(This consent would allow us to talk to vendors and service providers in order to fund the items requested; otherwise, we cannot release any information, even a name.)

FAMILY EASE REQUEST FORM

IN ORDER FOR REQUESTS TO BE PROCESSED Documentation from a Professional (Physician, Therapist, Doctor) stating the needs for goods/services (Letter of Recommendation) **IS required** with this Section

Family Information:

Family Name:
_____

Participant Name:
_____

Social Security Number: _____
Date of Birth:_____

Address:
_____

_____

County:_____

Home Phone Number: _____ Work Phone:_____
Cell Number:_____

Please give a description of the services or items requested (Documentation from a Professional (Physician, Therapist, Doctor) stating the needs for goods/services **IS Required** with this Section):

_____

_____

_____

Please give the approximate cost of your request: _____

ALL INFORMATION MUST BE COMPLETE FOR REQUEST TO BE PROCESSED For Office Use Only:

Payment Information:

Total Cost:_____ Total Amount to be Paid:_____
Reimbursement to: Family _____ Service _____
Date of Payment to: Family _____ Service _____

ISP/IFSP Information:

Date ISP/IFSP Sent to Family: _____