



United Cerebral Palsy of Middle Tennessee

Rutherford County Family Support Program

P.O. Box 10996

Murfreesboro, TN 37129

Phone: 615-796-3341

Fax: 615-369-3085

Email: Jo_VerMulm@ucpnashville.org

Website: www.ucpmidtn.org

Dear Applicant,

Thank you for your interest in the Family Support Program, Rutherford Co which is facilitated by United Cerebral Palsy of Middle Tennessee. The funding of this program is made possible from the State of Tennessee through the Department of Intellectual and Developmental disabilities, and as such, certain eligibility requirements apply.

Before you can be considered for assistance you must provide all of the information required in the application package. Proof of disability, proof of residence in Rutherford Co. and proof of citizenship status are required. Examples of accepted documents are listed on enclosure checklist. The completed application and supporting documents may be submitted to me at the address on this letterhead. Please make sure you have the appropriate postage on the envelope. You may also fax your materials to me at 615-369-3085 or send them via email in PDF format. If you do not receive confirmation that your application has been received within 7 days of sending it, you should call and follow up.

Each year, the Local Council develops a list of priorities that are utilized in consideration of applications. The determination regarding whether your request is appropriate for the program is made by the Local Council after eligibility review. The Local Council also determines the amount, if any, that we can allocate for your services. The Local Council meets quarterly. Assistance from the Family Support Program is restricted to disability-related expenses. There is no guarantee that we will have funding available for all eligible applicants. Family Support is not an entitlement program.

Please feel free to contact me if you have questions about the application and/or the Family Support Program.

Sincerely,

Jo Ver Mulm

Rutherford County Family Support Program Coordinator



**Department of Intellectual and Developmental Disabilities
Family Support Intake Form**

Date: _____

Name of Family Member with a Severe or Developmental Disability: _____

Social Security #: _____ Date of Birth: _____

Name of Primary Family Member(s), if different than above: _____

Applicant's Address: _____ Phone: _____

Phone: _____

County of Residence: _____ E-mail: _____

Reason for referral to Family Support Program (include information on the impact of disability on the family)

Potential Support Services Needed/Requested (Check services needed):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Before/After Care | <input type="checkbox"/> Home Modifications | <input type="checkbox"/> Specialized Equip. & Repair/Maintenance | <input type="checkbox"/> Recreation/Summer Camp |
| <input type="checkbox"/> Behavior Services | <input type="checkbox"/> Home Maker Services | <input type="checkbox"/> Specialized Nutrition/Cloth/Supplies | <input type="checkbox"/> Vehicle Modifications |
| <input type="checkbox"/> Day Care | <input type="checkbox"/> Nursing/Nurses Aide | <input type="checkbox"/> Training | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Personal Assistance | <input type="checkbox"/> Transportation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Respite | <input type="checkbox"/> Health Related | <input type="checkbox"/> Other: _____ |

Is the Individual or Family Currently Receiving Other Services (Check all that apply)?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Adoption Assistance | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Residential Services | <input type="checkbox"/> TennCare |
| <input type="checkbox"/> CHOICES Waiver | <input type="checkbox"/> Medicare | <input type="checkbox"/> Social Security Income | <input type="checkbox"/> Vocational Rehabilitation |
| <input type="checkbox"/> DIDD Waivers | <input type="checkbox"/> Nursing Services | <input type="checkbox"/> Social Security Disability Income | <input type="checkbox"/> PACE |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> OPTIONS Program | <input type="checkbox"/> Supported Living | <input type="checkbox"/> ECF |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Tenn. Early Intervention System | <input type="checkbox"/> Other: _____ |

To comply with Title VI the following information is requested:

- | | | | |
|------------------------------------|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> African-American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other |
| <input type="checkbox"/> Female | <input type="checkbox"/> Male | | |

Family Support Intake Form, page 2

If someone other than the family/individual is making a referral:

Name of individual making referral to Family Support: _____

Agency: _____ Phone: _____

Address: _____

Primary Disability – Check which of the following major disability categories is most relevant to the family member with a severe disability as a primary diagnosis:

- | | |
|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Neurological Impairment |
| <input type="checkbox"/> Deaf and/or Blind | <input type="checkbox"/> Orthopedic Impairment/ Physical Disability |
| <input type="checkbox"/> Health Impairment | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Developmental Delay (Birth - 8 y.o.) |
| <input type="checkbox"/> Other | |

Did the person’s primary disability occur:

- Prior to age 22
- At age 22 or after

By signing and dating this form, I, the person supported or legal representative, indicate that all of the information above is true and accurate. Furthermore, I understand providing invalid, inaccurate or incomplete information may result in denial of a claim, disenrollment from the program and/or criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.

Signature of Person Supported or Legal Representative

Date

How was this information obtained (i.e. face to face visit, by phone)?

NOTES



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Additional Questions for the Rutherford Co. Family Support Program

Tell us where you live:

- At home alone
- At home with family
- In a Supported Setting (nursing home, group home, foster care, etc.)

Is anyone else in your family/household (siblings, parents, etc.) applying for or currently receiving assistance from Family Support?

- YES NO

If yes, please list name(s)_____

Are you applying or have you applied and received assistance through the Family Support Program in another TN County for the '19-20 program year?

- YES NO

Please provide any other information below you feel may be helpful in ascertaining the needs and the level of functional disability for this applicant:

Name of Applicant: _____ Date _____

Name of Person Completing this Form on behalf of Applicant: _____

The Family Support Program is established to provide services to persons with specific functional limitations. Please complete the following information related to functional limitations of the individual applying for services. NOTE: Do NOT simply check "Child/Does not Apply" on every line. Think about how your child compares to typically developing peers of the same age. This options should only be selected in questions (like "ability to earn a living") where the answer is unknown. **Answers from this form alone do not determine eligibility for the Family Support Program.**

Physical Limitations	Child/Does		
	Yes	No	not Apply
Able to walk without supports or assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to sit up without supports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to transition from chair to standing or from bed to standing position unassisted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to use arms and hands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to dress without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to eat without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to go to the bathroom and bathe without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to see clearly enough to read? (If applicant wears correctives lens, can they see clearly when wearing glasses, contacts etc.?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to hear without a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to speak clearly enough to be understood by others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral and Intellectual Limitations	Child/Does		
	Yes	No	not Apply
Able to behave in a generally socially acceptable manner without guidance and supervision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to self-supervise? (i.e., can be left alone for long periods of time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to self-regulate emotions/emotional behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to comprehend and follow simple directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Life Skills Limitations	Child/Does		
	Yes	No	not Apply
Able to earn a living or care for others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to make critical decisions and manage appointments for self?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does this person drive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to conduct personal finances without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Enclosure Checklist

Use this checklist to ensure all required items are enclosed. Your application cannot be considered without all required information.

[] **Family Support Program Application**: Completed, signed and dated.

[] **Updated Documentation of Disability**: A recent letter or statement from your physician that describes your disability explains specifically how your life activities are limited. Note that if the disability documentation you submit does not include adequate detail about your limitations additional information may be requested. Statements obtained from urgent care/walk-in clinics will not be accepted. Eligibility for the Family Support Program is **not** based on the receipt of Social Security Disability benefits.

[] **Documentation of Residency in Rutherford County**: Acceptable documentation would include copy of a utility (gas, water, or electric) statement or government document with the name of the applicant (or applicant's head of household) showing the applicant's street/home address and dated within the last 60 days. Please note: Post Office Box addresses are not acceptable evidence of residency, neither are bank, credit card statements or medical bills.

[] **Proof of U.S. Citizenship or Qualified Alien Status**:

Examples of Documentation that can be used to verify citizenship:

- *A United States Government-issued certified birth certificate*
- *A valid, unexpired US Passport or US Passport Card*
- *A United States certificate of birth abroad (DS-1350 or FS-545)*
- *A report of birth abroad of a citizen of the United States (FS-240)*
- *Certificate of Citizenship (N560 or N561)*
- *Certificate of Naturalization (N550, N570, or N578)*
- *A United States citizen identification card (I-197, I-179)*
- *Applicants who claim for qualified alien status should contact the State or Regional Family Support Offices, (State, phone 615-532-6552, Regional, 615-231-5057) for clarification on required documentation.*