United Cerebral Palsy of Middle Tennessee
Rutherford County Family Support Program
Claressa Ham, Family Support Coordinator
P.O. Box 10996
Murfreesboro, TN 37129
Phone: 615-796-3341
Fax: 615-369-3085
Email: Family_Support@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,

Claressa Ham
Family Support Coordinator
United Cerebral Palsy of Middle TN

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):

☐ Before/After Care	☐ Home Modifications	☐ Specialized Equip. & Repair/Maintenance	☐ Recreation/Summer Camp
☐ Behavior Services	☐ Home Maker Services	☐ Specialized Nutrition/Cloth/ Supplies	☐ Vehicle Modifications
☐ Day Care	☐ Nursing/Nurses Aide	☐ Training	☐ Other: _____
	☐ Personal Assistance	☐ Transportation	☐ Other: _____
☐ Family Counseling	☐ Respite	☐ Health Related	☐ Other: _____

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

☐ Adoption Assistance	☐ Medicaid	☐ Residential Services	☐ TennCare
☐ CHOICES Waiver	☐ Medicare	☐ Social Security Income	☐ Vocational Rehabilitation
☐ DIDD Waivers	☐ Nursing Services	☐ Social Security Disability Income	☐ PACE
☐ Food Stamps	☐ OPTIONS Program	☐ Supported Living	☐ ECF
☐ Foster Care	☐ Private Insurance	☐ Tenn. Early Intervention System	☐ Other: _____

To comply with Title VI the following information is requested:

☐ Caucasian	☐ African-American	☐ Hispanic	☐ Other
☐ Female	☐ Male		

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:

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Deaf and/or Blind
- ☐ Health Impairment
- ☐ Traumatic Brain Injury
- ☐ Other
- ☐ Intellectual Disability
- ☐ Neurological Impairment
- ☐ Orthopedic Impairment/ Physical Disability
- ☐ Spinal Cord Injury
- ☐ Developmental Delay (Birth - 8 y.o.)

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

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:Family_Support@ucpnashville.org
Website: www.ucpmidtn.org

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 ’20-21 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	**Yes**	**No**	**Child/Does not Apply**
Able to walk without supports or assistance?	☐	☐	☐
Able to sit up without supports?	☐	☐	☐
Able to transition from chair to standing or from bed to standing position unassisted?	☐	☐	☐
Able to use arms and hands?	☐	☐	☐
Able to dress without assistance?	☐	☐	☐
Able to eat without assistance?	☐	☐	☐
Able to go to the bathroom and bathe without assistance?	☐	☐	☐
Able to see clearly enough to read? (If applicant wears correctives lens, can they see clearly when wearing glasses, contacts etc.?)	☐	☐	☐
Able to hear without a hearing aid?	☐	☐	☐
Able to speak clearly enough to be understood by others?	☐	☐	☐

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

Life Skills Limitations	**Yes**	**No**	**Child/Does not Apply**
Able to earn a living or care for others?	☐	☐	☐
Able to make critical decisions and manage appointments for self?	☐	☐	☐
Does this person drive?	☐	☐	☐
Able to conduct personal finances without assistance?	☐	☐	☐

Enclosure Checklist

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

Required with every application:

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

Required with first-time application and periodically as requested:

[ ] **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.

Required with every application:

[ ] **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 ir 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, 1-179)*

U.S. Birth Certificate is required with first-time application only

Qualified alien status, if applicable, is required with every application

- *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.*