B & B Care Services, Inc.

P.O. Box 1040 • Springfield, GA 31329 • 855-754-0817 • 912-754-0817 • Fax 912-754-1534

June 14, 2016

Application for State Funded Family Support and Respite

Greetings,

B&B Care Services, Inc is a state-funded provider of Family Support and Respite Services for individuals with Autism and Developmental Disabilities. State Funded Family Support and Respite are non-entitlement programs which provide flexible funding to support an individual and their family so that they may continue living in their own home and/or community.

State Funded Family Support can provide funding for various disability related services, including therapy, recreation, family training, transportation, medical & dental, and community supports. To qualify for State Funded Family Support, the individual must have an Intellectual or Developmental Disability, Autism, or Traumatic Brain Injury (prior to age 22) diagnosis and be above the age of three. The individual can not be receiving services through the NOW or COMP waiver or Department of Family and Children Services, however may receive services from the Short Term or Long Term Planning List through the GA Department of Behavioral Health and Developmental Disabilities Regional Field Office or other waivers. Individuals may only receive Family Support Services through one provider agency at a time.

State Funded Respite is designed to allow the caregiver or the individual a break from caregiving responsibilities on a scheduled (maintenance) or emergency basis. B&B Care Services contracts with many licensed, professional respite agencies to provide services. Maintenance Respite may be utilized up to thirty (30) 6-hour days per fiscal year and Emergency Respite is evaluated on an as-needed schedule.

Please complete the attached Individualized Family Support Application and return to our office via e-mail, fax, or mail. Please include the individual's birth certificate and appropriate diagnosis documentation. Once complete and received, our office will review and transmit the documentation to the GA DBHDD Regional Field Office for approval. Following approval, I will meet with your family to identify the individual's needs and complete your Individualized Family Support Plan.

If you have any questions, please feel free to contact B&B Care Services, Inc.

Respectfully,

Pauline Shaw
Family Support Coordinator
B&B Care Services, Inc.

pshaw@bandbcare.com
(912) 754-0817
(855) 754-0817
(912) 754-1534 Fax

Individualized Family Support Application

Section I: Demographic Information

Date of Application: _____

Individual Name: _____
Social Security Number: _____
Gender: Male Female 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: _____ Public (Medicaid #): _____

Family/Caregiver Name: _____ Age:_____
Relationship to Individual: _____ □ Legal Guardian of Individual

Mailing Address: _____ County: _____
Mailing Address: _____ Phone: _____
City, State, Zip: _____ 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 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)	□ Comprehensive Waiver (Comp)
□ DBHDD Planning List	□ SOURCE
□ ICWP	□ GAPP
□ CCSP	□ DBHDD State Funded Services
□ Deeming Waiver (Katie Beckett)	□ Child Care Assistance (CAP)
□ Vocational Rehabilitation	□ Adoption Assistance
□ Food Stamps	□ Other:
□ Individual Education Plan	□ Other:
□ ADRC-Options Counseling	□ 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	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.
FY16 Health Information & Release

July 1, 2015 – June 30, 2016

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:
Telephones	Day:	Evening:		Other:
Age:	DOB:	Race/Ethnicity:		Marital Status:
Religious Preference:		Legal Status: (Guardian)		
Medicare:		Medicaid:		
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:	

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

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

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

Allergies (if *none* specify NKA)

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

Medical Diagnoses

B&B Care Services, Inc.
FY16 Health Information & Release

July 1, 2015 – June 30, 2016

Chronic and ongoing medical issues, including how it affects the person'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 take medication:

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

FAMILY SUPPORT SERVICES AGREEMENT

This is an agreement between the Family, on behalf of the Identified Individual and his/her family (as defined in the Family Support Policies) and the Provider/Agency regarding Family Support Services.

Agreement Start Date: _____ **Agreement End Date:** _____

INDIVIDUAL AND APPLICANT INFORMATION

Individual's Printed Name: _____

Individual's Date of Birth: _____

Individual's Social Security Number: _____

Individual's Address

Street Address: _____

Street Address: _____

City, State, Zip: _____

Individual's Phone Number: _____

Printed Name of Applicant: _____
(Person applying on behalf of individual)

Relationship to Individual: _____

Applicant's Address

Street Address: _____

Street Address: _____

City, State, Zip: _____

Applicant's Phone Number: _____

PROVIDER INFORMATION

Provider / Agency Name: B&B Care Services, Inc.

Provider/Agency Address

Street Address: 303 South Laurel Street

Street Address: P.O. Box 1040

City, State, Zip: Springfield, GA 31329

Provider/Agency Phone Number: (912) 754-0817

Provider/Agency Fax Number: (912) 754-1534