

## West Virginia Family and Community Support Application

Thank you for applying for funds through the WV Family and Community Support program. The Program provides individual services and supports to families who have a member with a developmental disability living at home. Family Support provides information on and referrals to community services and supports, as well as, limited flex funds when all other support options have been exhausted. **Family and Community Support Flex Funds are to be used as the funding of last resort.**

Please **print clearly** and **complete the entire application** including initials and signatures on the last page in order for your application to be considered at the next committee meeting. Please **send your completed application to your Family Support Regional Council.**

***If you require this application in an alternative format, please contact your regional provider.***

Region	Agency	Contact Information	Counties
1	Brooke Hancock FRN c/o Ohio County FRN	56 13th Street Wheeling, WV 26003 304-748-7850	Brooke, Hancock, Marshall, Ohio, Wetzel
2	East Ridge Health Systems	235 South Water Street Martinsburg, WV 25401 304-263-8954	Berkeley, Grant, Hampshire, Jefferson, Hardy, Mineral, Morgan, Pendleton
3	Westbrook Health Services	2121 E 7 <sup>th</sup> Street Parkersburg, WV 26101 304-485-1721	Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood
4	United Summit Center	6 Hospital Plaza Clarksburg, WV 26301 304-623-5661	Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, Upshur
5	Prestera Center	511 Morris Street Charleston, WV 25301 304-341-0511	Boone, Cabell, Clay, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam, Wayne
6	Southern Highlands Community Mental Health Center	200 – 12 <sup>th</sup> Street Extension Princeton, WV 24740 304-425-9541	Fayette, Greenbrier, McDowell, Mercer, Monroe, Nicholas, Pocahontas, Raleigh, Summers, Webster, Wyoming

Applicant Name			Date of Birth	/ /
Address			County of Residence	
* Phone Number		* Email Address		

**\* Please indicate by circling your preferred method of communication - phone or email.**

Date of Application	/ /	Do you own or rent your home?	
Did someone help with the completion of the application?		If yes, what is the relationship to the applicant?	
What is the contact information for the individual who helped with the application?	Name		
	Phone Number		
	Email Address		

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Have you applied for Family & Community Support before?		What is your race/ethnicity?																									
What is your Developmental Disability? (Medical Documentation is required)																											
How did you learn about the Family & Community Support Program?																											
<p>Please indicate which State supports and services you access as well as private insurances you have.</p> <p>Please check all that apply. If you are unsure about any of these, please indicate with a “?” mark.</p> <p>If you need additional information, please contact your Family Support Coordinator.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">Aged and Disabled (A&amp;D) Waiver</td></tr> <tr><td style="padding: 2px;">Child with Disabilities Community Services Program (CDCSP)</td></tr> <tr><td style="padding: 2px;">Children with Special Health Care Needs (CSHCN)</td></tr> <tr><td style="padding: 2px;">Discount Utility Program</td></tr> <tr><td style="padding: 2px;">Intellectual/Developmental Disabilities (I/DD) Waiver</td></tr> <tr> <td style="padding: 2px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Are you on the I/DD Waiver Wait List?</td> <td style="width: 5%;"></td> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%;"></td> <td style="width: 5%; text-align: center;">No</td> </tr> </table> </td> </tr> <tr><td style="padding: 2px;">Low Income Energy Assistance Program (LIEAP)</td></tr> <tr><td style="padding: 2px;">Medicaid</td></tr> <tr><td style="padding: 2px;">Medicare</td></tr> <tr><td style="padding: 2px;">Non-Emergency Medical Transportation (NEMT)</td></tr> <tr><td style="padding: 2px;">Personal Care</td></tr> <tr><td style="padding: 2px;">Private Insurance</td></tr> <tr><td style="padding: 2px;">Temporary Assistance for Needy Families (TANF)</td></tr> <tr><td style="padding: 2px;">Traumatic Brain Injury (TBI) Waiver</td></tr> <tr><td style="padding: 2px;">School Clothing Allowance (SCA)</td></tr> <tr><td style="padding: 2px;">Supplemental Nutrition Assistance Program (SNAP)</td></tr> <tr><td style="padding: 2px;">WV State Health Insurance for Children (WVCHIP)</td></tr> <tr><td style="padding: 2px;">Women Infant and Children (WIC)</td></tr> <tr><td style="padding: 2px;">Other – please specify –</td></tr> </table>	Aged and Disabled (A&D) Waiver	Child with Disabilities Community Services Program (CDCSP)	Children with Special Health Care Needs (CSHCN)	Discount Utility Program	Intellectual/Developmental Disabilities (I/DD) Waiver	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Are you on the I/DD Waiver Wait List?</td> <td style="width: 5%;"></td> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%;"></td> <td style="width: 5%; text-align: center;">No</td> </tr> </table>	Are you on the I/DD Waiver Wait List?		Yes		No	Low Income Energy Assistance Program (LIEAP)	Medicaid	Medicare	Non-Emergency Medical Transportation (NEMT)	Personal Care	Private Insurance	Temporary Assistance for Needy Families (TANF)	Traumatic Brain Injury (TBI) Waiver	School Clothing Allowance (SCA)	Supplemental Nutrition Assistance Program (SNAP)	WV State Health Insurance for Children (WVCHIP)	Women Infant and Children (WIC)	Other – please specify –		
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### Requests for Services and Supports

In this section, please indicate what goods/services you are requesting. Please fill out all sections clearly and completely. *Depending on the nature of your request, there may be additional steps or resources to explore before Family and Community Support Flex Funds may be considered.* All requests will come with some contribution from family members. **Please attach at least two (2) estimates for the items requested.**

What services/supports are you requesting Family and Community Support help with?			
What is the full cost of the request? Please attach at least 2 estimates		Please indicate what your family can contribute to help meet the need? <i>Examples may include but are not limited to: money, installation, picking up requested items.</i>	

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If applicable, was this request submitted to your insurance?		Was the request approved or denied?	
Please describe insurance details:	Approved		Denied
	Coverage Amount:	Reasons for denial:	
<p>Please list resources you have explored to meet your request and the results. Please be specific in your explanations.</p> <p><i>Resources may include: donations, donated services, fund raising, etc.</i></p> <p>Feel free to attach additional pages as needed.</p>			
<p>Please take a moment and describe to the Family Support Council how this request for goods/services will benefit your family.</p> <p>Feel free to attach additional pages as needed.</p>			

**Please read the following statements and initial that you have read and understand them.**

	1. Applications are presented to the Regional Family Support Council only by an identification number to preserve your privacy.
	2. Family and Community Support Flex Funds are not guaranteed to be available. You may receive all, some or none of the funds you have requested.
	3. Specific guidelines regarding distribution of funds may vary from agency to agency within the State.
	4. By initialing, I give permission to the Regional Family Support Coordinator to contact the relevant individuals directly related to the completion of the Family Support application process. This includes any vendors directly receiving funds, family members and/or their designee. Any additional consent will be requested on an individual basis.

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		Third Parties that may be contacted	
	5. If you change the reason for needing the funds, you must complete the following steps: <ol style="list-style-type: none"> <li>a. Contact the Regional Family Support Coordinator</li> <li>b. Complete a new application for the Family and Community Support Program</li> <li>c. If you have already received a check for your initial request for funding, you <b>MUST</b> return this check to the Regional Family Support Coordinator.</li> </ol>		
	6. All applicants will receive a letter detailing the results of their application results. If funds are approved, further instructions will be included in this letter.		
	7. Keep all original receipts for items purchased with Family Support Funds. Submit a copy of these receipts to the Regional Family Support Coordinator within 30 days of spending the monies. <b>(Cancelled checks are not accepted as receipts)</b>		
	8. Family Support funds are not available to reimburse funds already spent by the family.		

You may attach additional pages to address any question on this application, or any other supporting documentation you wish for the Family Support Council to review as a part of your application.

**By signing this application, you agree that all information provided is accurate and the application is complete.**

\_\_\_\_\_  
Signature of Individual or Family Requesting the assistance from Family and Community Support

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship to Applicant

\_\_\_\_\_  
Signature of Individual Assisting with completion of the Family and Community Support Application Process

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship to Applicant

<b>DO NOT WRITE IN THIS BOX - OFFICE USE ONLY</b>							
Date of Meeting		ID Number					
Funds Requested		Council Recommendation	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; padding: 2px;">Approved</td> </tr> <tr> <td></td> <td style="padding: 2px;">Denied</td> </tr> </table>		Approved		Denied
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	Denied						
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