June A. DiPolito
Executive Director

PINELAND BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
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Serving: Appling - Bulloch - Candler - Evans - Jeff Davis - Tattnall - Toombs - Wayne Counties

Greetings Families, 8/21/20

I hope this letter finds you all well. What a year we have had already! Everything has changed, and nothing has stayed the same. Please accept my apologies for not sending this update out before now, but with everything that has been going on, it was pushed back so a lot of other things in our lives.

As many of you know, there were substantial cuts to the state budget this fiscal year. DBHDD and Family Support were no exception to that. It looks like now that we will be operating on about one third of our normal budgets. Many people were displaced from their services across the state, and understandably the state is asking that these individuals take precedence with Family Support funding.

You are probably asking yourselves....Okay, but what does this mean for me?

Starting this year, Family Support will look a lot different to many. It will be reserved for those "most in critical need". Please bear in mind that Family Support has never been AN ENTITLEMENT PROGRAM, and no amount of funding if any is guaranteed.

The recreation / leisure and therapies have been cut out.

The utility and rental assistance have been cut out.

And more cuts are coming. It is time for us all to focus in on what we REALLY need for our kids and our families in order to keep their individual in the home, and not seek outside placement (which is the basis of why Family Support started to begin with). Times are tough, but we as families have to be tougher!

I hate to be the bearer of bad news, but this is where we are. Please bear with me, as even more changes are coming, but for now please carefully review and complete the attached paper work. Once I receive this back, I will be able to get everyone back on track and start assessing critical need. Please if possible scan to tstanfield@pinelandcsb.org. If you do not have access to a scanner, please take the completed paperwork to any Pineland facility and ask them to scan to me.

Thanks for your patience and understanding,

Ty Drury

Ty S. Drury
Family Support Coordinator
Pineland BHDD

Name (Individual receiving services)_____ _Date of Birth _____

Please complete this questionnaire to the best of your ability, and sign. This will assist in developing your individuals Family Support Plan for the Fiscal Year, and will determine his/her service categories and funding allotments.

1. What makes your individual happy? What makes him/ her smile? (this can be favorite food, places, people, things)

2. What are your hopes and expectations for you individual? What do you want to be sure they have access or exposure to?

3. Do you ever get stressed out and feel overwhelmed with caring for your individual? If so, explain what your stressors may be.

4. Family dynamics- Who are the members currently living in the household Ex: brother, sister, mother, father, aunts, grandmother/father, etc)

5. What activities does your individual or family as a whole currently take part in outside of the home?

6. Do you ever find yourself paying out of pocket expenses related to medical, dental or vision care?

7. Are structural changes to your home needed which would allow more accommodation to his/her needs? (fencing for flight risks, wheelchair ramps, door widening, bathroom modifications, etc.) Explain.

8. Has your individual been prescribed any type of specialized nutrition such as Ensure, PediaSure or Boost? Does your individual use a feeding tube? If so, is your individual receiving this supplement through any other source such as Medicaid or other source?

NOTE: We now need copies of current prescriptions in order to provide nutritional supplements and incontinence supplies. Please attach a copy of current prescriptions

Type	Frequency (how many are prescribed a day)	Provided by another source (such as Medicaid or Private Insurance)
		__Yes __No

9. Does your individual use any type of incontinence supply (diapers, wipes, gloves, chux, etc)? If so, please list specific brand/ size of diapers/ wipes/ chux/ gloves and how many of each are used in a typical day. If your individual uses any other incontinence supplies not listed below, please add in available spaces.

NOTE: We now need copies of current prescriptions in order to provide nutritional supplements and incontinence supplies. Please attach a copy of current prescriptions

	Circle one	Preferred Brand/ Type	Weight	Hip Measurement	Size	How many are used in a typical day	Provided by any other source
Diapers	Yes No						Yes No
Pull-Ups	Yes No						Yes No
Wipes	Yes No						Yes No
Chux (underpads)	Yes No						Yes No
Gloves	Yes No						Yes No

10. Do you ever travel over 100 miles round trip to transport your individual to appointments or procedures?

11. Does your individual require after school care or daycare? If so, have you applied for CAPS? **Note: In order for Family Support to provide assistance with child care/ after school care, we must have a CAPS denial letter on file. CAPS can be applied for online at www.compass.ga.gov**

12. Do you have an email address? If so please list it here:

_____

I _____ have answered these questions honestly, and to the best of my ability. I understand that the answers to these questions will determine the level of support my individual receives through the Family Support Program. I understand that Family Support is not an entitlement program and is to be used only as a payer of last resort. All other funding options must be exhausted before utilizing Family Support Funding.

Signature_____ Date_____

FAMILY SUPPORT SERVICES AGREEMENT

This is an agreement between the 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 Family Member:
(Person Applying on behalf of individual) _____

Relationship to Individual: _____

Family Member's Address

Street Address: _____

Check if Same as Individual

Street Address: _____

City, State, Zip: _____

Family Member's Phone Number:
Check if Same as Individual

PROVIDER INFORMATION

Provider/ Agency Name: _____

Provider/Agency Address

Street Address: _____

Street Address: _____

City, State, Zip: _____

Provider/Agency Phone Number: _____

Provider/Agency Fax Number: _____

Individual/Applicant Family Support Services Acknowledgements:

Initials	I, as the Individual/Applicant attest and agree with the following statements:
_____	Attests that the Individual is residing in the family home within the community or the Family Support funds are to be used to prepare the home and the family for the return of the Individual (i.e., member with the developmental disability) from alternate care placement.
_____	Understands and acknowledges 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.
_____	Understands that a determination of eligibility for Family Support Funding does not guarantee receipt of and funding for such services/goods.
_____	Understand 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 the NOW, and COMP Waivers.
_____	Understand and acknowledge that Family Support Services are provided only in the event that comparable services are not available and/or cannot be funded through other programs (including, but not limited to Medicaid, Medicare, charitable organizations, etc.).
_____	Attests that the Individual and his/her family will seek other funding resources for similar or related Services/goods, when such funding resources are identified as a payer of such services/goods.
_____	Understand and acknowledges that Family Support Services is a needs-based program.
_____	Understand and acknowledges that services/goods requested are not available through the Individualized Education Plan (IEP) and protected by Individuals with Disabilities Education Act (IDEA), and the responsibility of funding through the Local Education Authority (LEA).
_____	Understands and acknowledges that funding levels may change without prior notification
_____	Understands and acknowledges that all funding available through Family Support Services will be used solely for the purpose(s) documented on the Individual Family Support Plan (IFSP), and to benefit the individual diagnosed with a Developmental Disability.
_____	Understands and acknowledges that all services and goods requested must be related to the developmental disability and are requested for the sole purpose of assisting the family to stay together as a family unit, and to assisting the individual to remain in the community setting.
_____	Understands and acknowledges that only the services/goods listed in the Individual Family Support Plan (IFSP) will be provided and such services/goods are limited to the rate, frequency, and funding identified. Any services/goods not listed on the Individual Family Support Plan are not eligible for funding and/or reimbursement.
_____	Understands and acknowledges that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.
_____	Understands the continued need for Family Support Services will be re-evaluated no less than annually.

Understands and acknowledges that the individual must present receipts or other documentation to verify any expenses for which the individual requests payment or reimbursement, and that all requests for reimbursement must comply with Family Support Services Policy. Understands that all direct reimbursement requests must be pre-authorized by the provider, and listed on the IFSP. Understands that any misrepresentations 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.

Understands and acknowledges that any misrepresentation of Individual's needs, will result in immediate discontinuation of services, in the Individual's lifetime restriction of receiving any future funds/services through Family Support Services and the Individual by the applicant will be responsible to paying back any funds received based on such misrepresentation(s) or misappropriation(s).

Understands and acknowledges that the Individual must provide supporting documentation verifying Family Support Services as the payer of last resort, including but not limited to; insurance denials, lack of insurance coverage, verification of lack of funding from community based resources.

Understands and acknowledges that any individual providing respite services as part of Family Support must be on a region maintained "List of Approved Respite Providers" prior to providing any respite Services. (Reimbursement for any Services provided prior to being approved, will not be eligible for funding under Family Support Services)

Understands and acknowledges that Family Support funds may not be used to reimburse funds already spent by the family prior to applying and being approved for Family Support Services, and/or may not be used to reimburse/fund services that are not specifically listed on the IFSP.

Understands and acknowledges 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.

Understands and acknowledges 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.

Understands and acknowledges that recipients of Family Support Services program, as a non-entitlement program are not eligible to file appeals for services/goods, and or changes to funding.

Understands and acknowledges specific guidelines regarding distribution of funds may vary from agency to agency within the state.

Understands and acknowledges that families can only receive Family Support Services from one Provider/Agency at time. Families agree only to change Provider/Agency with justification regarding service needs justification, and cannot change agencies based on funding limits only.

Agrees 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 Individual's efforts to obtain services through other programs, and regarding 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. Provider will develop an Individual Family Support Plan (IFSP) for the Individual. Provider will develop the IFSP in consultation with Individual and Applicant.
2. Provider will designate a Family Support Coordinator as a single point of contact to work with Individual and Family in obtaining Family Support Services.
3. Provider will review the IFSP annually, and revise based on resources or needs.
4. Provider will inform the Individual/Applicant in writing of Applicant's rights to participate in the IFSP and IFSP reviews, and to review a denial, discontinuance, or reduction in benefits.

Both parties agree as follows:

1. The Provider and Individual/Family will sign both copies of this agreement and return one signed copy to the appropriate DBHDD Regional Office. A copy will be kept on file by the Provider for State Review, 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 will 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, 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's Signature	Print	Date
Family Member's Signature	Print	Date
Family Support Coordinator's Signature	Print	Date
Family Support Coordinator's Name	Print	

Individualized Family Support Plan (IFSP) Annual Review

Describe any changes to the services and goods from previous plans and provide justification for any changes:

SIGNATURES

Family Support Agreement Signed: ☐ Yes ☐ No

I/We attest that we were informed of our right to participate in the development of this Individualized Family Support Plan, and were given the ability to make any changes to the services and goods identified based on my/our family priority of needs for services/goods. . I/We understand that Family Support Services is a non-entitlement program and Family Support Services Provider Agency cannot fund all the service and goods that I/We may request, and that funding levels can and might change from each funding year and are subject to funding limitations.

I/We agree with the Individual Family Support Plan, Family Support Agreement, and the disclaimers above:
☐ Yes ☐ No

Signature	Date
Parent/Guardian Signature	Date
Family Support Coordinator Signature	Date

Pineland Behavioral Health and
Developmental Disabilities

Name of Individual

Social Security Number AND/OR Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION- STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: _____
(Name of health care provider holding the information-releasing agency)

_____
(Address) (Phone/Fax)

To: _____
(Name of Person or Agency to whom information should be given-requesting agency)

_____
(Address) (Phone/Fax)

_____ I authorize the following information from my records (and any specific portion thereof):
Initials _____

_____ I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below) If I am a minor,
Initials my parent/guardian/court-ordered custodian and I **BOTH** must initial here in order for this information to be released.

_____
Initials

_____ I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus)
Initials and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions

The above information is for the purpose of: Family Support ordering/ paying/ shipping

1. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that the Agency or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)
   ☐ one (1) year OR ☐ the period necessary to complete all transactions on matters related to services provided to me.
   I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.

_____ _____
Date **Signature of Individual**

_____ _____
Signature of Witness (Title or Relationship to Individual) **Signature of (check one):**
☐ **Parent** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor**
☐ **Agent designated by Individual's Advance Directive**

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Suite 22.240 Atlanta, GA 30303-3142.

_____ _____
Date this authorization is revoked by Individual **Signature of Individual or legally authorized Representative**

FAMILY SUPPORT GOODS AND SERVICES REQUEST

COUNTY : _____

Revised 7-1-19

Date of Request: **Individual Requesting:** **Phone:** **For (Individual Name):** **Address:** **Phone:** **Date of Birth:** **Email address:** ***Do you own or rent your home?	***FOR OFFICE USE ONLY* PLEASE LEAVE THIS SECTION BLANK*** **Check Payable to:** **Address:** **Amount:** **Please return to:** **Ty S. Drury** **Family Support Coordinator** **Pineland BHDD** **Phone: (912)654-8020 Fax: (912)654-3050** **Email: tstanfield@pinelandcsb.org**

Please provide a short description of the item/service you are requesting as well as an estimated price. (please include any item numbers, web addresses, etc.

The goal of Family Support is to sustain and enhance the quality of family/home life so that the individual with developmental disabilities can remain within a nurturing family in his/her home. Please provide a short description of how this item will make a positive difference in the life of the person with a disability as well as the lives of all family members.

Have there been any changes in services received from other sources since your application for Family Support was submitted to the region? Yes___ No____
If yes please provide explanation below:

_____

_____

I _____declare that the above requested items are not made available to me, or to my family though any other source.

Signature of Applicant/ Guardian_____Date_____

Please do not write below this line. For Office Use Only.

Approved___ Denied___ Family Support Coordinator: _____Date_____
Approved___ Denied___ Financial Department: _____Date_____
If denied, state reason here:

_____

Expense Account number: _____ CC type and #:_____
Date Paid: _____ Check #:_____