DIRECTIONS FOR COMPLETION OF APPLICATION

PARENT/FAMILY MEMBER'S NAME: Enter the name of the parent or family member with whom the child(ren) with special needs resides. This person will be the contact person for the project coordinator.

ADDRESS, CITY AND ZIP CODE: Enter the mailing address, city, and zip code for the above named person.

HOME PHONE: Enter the home phone number for the above named person.

WORK PHONE: If it is permissible to contact you at work, enter the work phone number for the above named person. If applicable, please indicate if it is the mother's or father's number.

NAME OF CHILD(REN) WITH DEVELOPMENTAL DISABILITY: Enter the full name of the child(ren) with a developmental disability.

DIAGNOSIS: Enter the child(ren)'s diagnosis. For example: mental retardation, autism, cerebral palsy, etc. A developmental disability is any severe, chronic disability of a person that: 1) is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) is manifested before the person attains age twenty-two; 3) is likely to continue indefinitely; 4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency; and 5) reflects the person's need for an array of generic services, met through a system of individualized planning and supports over an extended time, including those of a life-long duration.

SOURCE: Enter the professional that determined the diagnosis. For example, name of psychologist, or physician. If you feel your child is eligible, but do not have a diagnosis, please call 1-800-265-9684 for further assistance.

DOB: Enter the child(ren)'s date of birth.

SSN: Enter the child(ren)'s social security number.

IEP/IFSP Y/N: If the child(ren) is on an Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP), enter Y or Yes. If the child(ren) is not on an IEP/IFSP, enter N or no.

RACE: Enter W for White, B for Black, H for Hispanic, AI or AN for American Indian or Alaskan Native, A or PI for Asian or Pacific Islander. This information is optional; it will be used for statistics and future program planning.

SEX: Enter M for Male, F for Female. This information is optional; it will be used for statistics and future program planning.

FAMILY MEMBER'S RELATIONSHIP TO CHILD WITH DEVELOPMENTAL DISABILITY: Identify relationship, e.g., mother, father, brother sister, etc.; also identify if child with special needs is a foster child.

DESCRIBE HOW THIS FUNDING WILL ASSIST YOUR FAMILY IN MEETING YOUR CHILD'S SPECIAL NEEDS: In a brief paragraph, describe special needs of child and how they affect the child and family.

Submit the complete application form to:

Department of Human Services, Statewide Family Support Program
E. Hwy. 34, Hillsview Plaza, c/o 500 E Capitol
Pierre, SD 57501-5070
Phone Toll-Free 800-265-9684 or 605-773-3438 FAX 605-773-7562

South Dakota

Within the heart of each community, everyone belongs.

DEPARTMENT OF HUMAN SERVICES

STATEWIDE FAMILY SUPPORT PROGRAM

WHAT IS FAMILY SUPPORT?

Family Support is a wide array of supports provided to families of children with a developmental disability. Supports are designed to help families get what they need to stay together. Family Support means different things to different families and can often prevent an unwanted out of home placement. A crucial part of Family Support is a pool of flexible funds that can be used to purchase supports not otherwise available. These funds can be used to assist families with expenses, such as the purchase of diapers or nutritional supplements.

Families belong together!

WHO IS ELIGIBLE?

Any family having a child with a developmental disability who lives in the family's home may be eligible. The child must be under the age of 22 and not already served by one of the other family support projects. There are no income guidelines for this program.

HOW DOES THE PROGRAM WORK?

A flexible pool of limited funds is available for eligible families to use to purchase services or supports that otherwise are not available. This may be assistance such as purchasing diapers, nutritional supplements, adaptive equipment, respite care, counseling, or making home modifications. Once a request is approved, the family will submit a voucher for the expense and the program will pay the vendor directly.

HOW TO APPLY?

Complete the attached application and return it to the address at the bottom of the application. If your family is approved for the program, you will receive verification from the program coordinator who will work with you regarding your request.

FUNDING

The program will exist as long as funds are available. Funds for the program are provided by the Governor's Planning Council on Developmental Disabilities and the Division of Developmental Disabilities.

APPLICATION FOR STATEWIDE FAMILY SUPPORT PROGRAM

(Please Print or Type)

***Please see back side for instructions for completing application.**

PARENT/FAMILY MEMBERS NAME: _____

ADDRESS: _____ CITY: _____

ZIP CODE: _____ HOME PHONE: _____ WORK PHONE: _____

E-MAIL ADDRESS: _____

NAME OF CHILD WITH DEVELOPMENTAL DISABILITY	DIAGNOSIS	SOURCE	DOB	SSN	IEP/ IFSP Y/N	R	S

The child's diagnosis and source of diagnosis must be listed above. Documentation of the child's diagnosis must accompany this application form. Documentation of the child's functional limitations such as birth to 3 evaluations, psychological-educational testing scores or other evaluations pertinent to the child's diagnosis should be submitted. If questions should arise regarding documentation, please call the toll free number listed below.

Family member's relationship to child with special needs: _____

Does your child with special needs reside in your home? _____ (yes or no)

What is your funding request (optional)?

_____

_____

What is the estimated cost (optional)? (Please submit an itemized estimate with this application)

_____

_____

Briefly describe how this funding will assist your family in meeting your child's special needs: _____

_____

_____

_____

_____

I understand for a child to be eligible for the Statewide Family Support Program he/she must have a diagnosed developmental disability, be under the age of 22, and must reside within a family member's home. I hereby attest that my child(ren) meets the eligibility requirements of eligibility for the Statewide Family Support Program.

SIGNATURE _____ DATE _____

Department of Human Services; Statewide Family Support Program
E. Hwy. 34, Hillsview Plaza, c/o 500 East Capitol, Pierre SD 57501
Phone Toll-Free 800-265-9684 or 605-773-3438
FAX 605-773-7562