

**DEVELOPMENTAL DISABILITIES SERVICES  
REQUEST FOR FUNDING FOR HOME AND COMMUNITY-BASED SERVICES**

**General Information**

Individual's Name:

Date of Birth:

Designated Agency:

Specialized Service Agency:

Contact Person:

Date of Request:

**Eligibility (choose one):**

Intellectual Disability

Pervasive Developmental Disorder/Autism Spectrum Disorder

**New or Existing Consumer (choose one):**

New Consumer: did not receive home & community based services in the past 12 months

Existing Consumer: has received home & community based services in the past 12 months

Check here if individual was funded with home & community based services in the past 12 months

**Department for Children & Families Custody Status (choose one):**

Aging out of DCF custody (attach current DCF budget)

Previously in DCF custody

**School Status (choose one):**

Still in school

High School graduate with employment

High School graduate without employment

**Refugee:**

Yes

No

**Children's Personal Care Services:**

Name:

**State System of Care Plan Funding Priorities (choose all that apply):**

- 1. Health and Safety:** Ongoing, direct supports and/or supervision are needed to prevent imminent risk to the individual's personal health or safety. (Priority is for adults age 18 and over)
  - a. "Imminent" is defined as presently occurring or expected to occur within 45 days.
  - b. "Risk to the individual's personal health and safety" means an individual has substantial needs in one or more areas that without paid supports put the individual at serious risk of danger, injury or harm (as determined through the needs assessment: see *Attachment E* for the needs assessment).
  
- 2. Public Safety:** Ongoing, direct supports and/or supervision are needed to prevent an adult who poses a risk to public safety from endangering others (Priority is for adults age 18 and over). To be considered a risk to public safety, an individual must meet the Public Safety Funding Criteria (see Section Three, page 14)
  
- 3. Preventing Institutionalizations – Nursing Facilities:** Ongoing, direct supports and/or supervision needed to prevent of end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). (Priority is for children and adults). Services are legally mandated.
  
- 4. Preventing Institutionalization – Psychiatric Hospitals and ICF/DD:** Ongoing, direct supports and/or supervision needed to prevent or end long term stays in inpatient public or private psychiatric hospitals or end institutionalization in and ICF/DD. (Priority for adults children and adults)
  
- 5. Employment for High School Graduates:** Ongoing, direct supports and/or supervision needed for a high school graduate to maintain employment upon graduation. (Priority for adults age 19 and over)
  
- 6. Parenting:** Ongoing, direct supports and/or supervision needed for a parent with developmental disabilities to provide training in parenting skills to help keep a child under the age of 18 at home. Services may not substitute for regular role and expenses of parenting; maximum amount is \$7,800 per person per year. (Priority is for adults age 18 and over)

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Name:

**Needs Assessment Summary - Factors are multiplicative not additive**

Level of Support Required:	None/Minimal	Moderate	Significant
Communication			
Self-Care			
Continence			
Independent Living Skills			
Health/Medical			
Mobility			
Wandering			
Sleep Disturbance			
Criminal Behavior			
Other Behavior Challenges			

**Applicant Mental Health Diagnosis** (choose all that apply):

- Agoraphobia                  Bipolar Disorder                  Borderline Personality Disorder (severe)
- Delusional Disorder      Major Depressive Disorder      Obsessive-Compulsive Disorder (severe)
- Psychotic Disorder      Schizoaffective Disorder      Schizophrenia                  Substance Abuse

**Caregiver factors:** (choose all that apply)

- Caregiver unable to work without support                  Death of caregiver
- Mental/physical issues                                                  Aging caregiver

**Resources Explored to Meet Needs:** Please indicate below which services and/or resources have been explored:

- Children & Family Services (DCF)                  Education/School                  Corrections
- Planned Parenthood                                  Employment & Training (DET)                  Economic Services
- Social Security                                                  Home Health/VHA/PNS                  MH-Adult
- Children’s Personal Care                                  Housing Subsidy                                  MH-Children’s
- High Technology Services                                  Work Stipend                                  Flexible Family Funding/Bridge
- Vocational Rehabilitation                                  Choices for Care Waiver
- Natural Supports                                                  Other (describe)

**Results (Explain why above does not meet the need or are inadequate, comment on all checked):**

Name:

**Narrative Description:**

**1)** Brief description of the individual, his/her current unmet support needs, and how they meet the System of Care Plan priorities.

**2)** How the proposed services will be utilized to support the unmet needs.

**3)** Expected outcomes of services.

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Name:

**Budget Information:**

**Requested Start Date:**

**Designated Agency:**

**Specialized Service Agency:**

**Equity**

**Public Safety**

**One-Time**

Specify Type & Amount of Support Requested in Categories below:	Current Agency Support	Cost of New Supports	Total Support 3=(1+2)	Funds Requested by the DA	Recommended Local	Recommended Equity/PS	DAIL Approved Allocation
<b>Service Plannng &amp; Coordination</b> ____ hr/wk @ \$____			\$0				
<b>Work Support</b> _____ hrs/wk direct supprt @ \$____/hr _____ hrs/wk transport @ \$____/hr			\$0				
<b>Community Supports-staffed/contracted</b> ____ hrs/wk @ \$____/hour			\$0				
<b>Respite Care</b> _____ hr/wk @ \$____ _____ days/yr @ \$____			\$0				
<b>Clinical Interventions</b> ____ hrs/wk/mo @ \$____/hr (individual) ____ hrs/wk/mo @ \$____/hr (group) ____ visits/yr @ \$____/hr (psychiatric) _____ hours/wk @ \$____/hr (other)			\$0				
<b>Crisis Support Individual</b>			\$0				
<b>Housing &amp; Home Support</b> Supp./Assist Living: _____ hrs/wk @ \$____/hr Staffed Living: _____ hrs/wk @ \$____/hr Group Living: _____ Annual Home Provider: _____ Annual Home Modification: _____ One time funding			\$0				
<b>Transportation</b> _____ miles/wk @ \$____/mile Van _____ Annual			\$0				
<b>Subtotal</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Agency Administration		\$0		\$0	\$0	\$0	\$0
<b>Total Cost</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0

Amount Funded by: USP

MH

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Name:

Recommendation by Local Funding

Approved:

Denied:

Recommended: \$

Comments/Changes:

Local Funding Committee Signature:

Date:

Recommendation by Equity Committee/Public Safety Committee:

Approved:

Denied:

Recommended: \$

Comments/Changes:

Equity/Public Safety Committee Signature:

Date:

Decision by Department:

Effective Date:

Continuation Date:

Reconsideration:

Total Dollars Allocated: \$

Comments:

Authorized Signature:

Date: