SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS APPLICATION FOR FAMILY SUPPORT FUNDING

The purpose of Individual and Family Support (IFS) funding is to provide, when needed, financial assistance to families who care for a person with an intellectual or related disability, autism, or traumatic brain injury, spinal cord injury or similar disability in order to improve an unsafe, risky or dangerous situation. In accordance with state law, IFS funding is not an entitlement program or a general public assistance benefit.

Because these funds are limited, IFS funding is not be available to:

- Those who are not DDSN eligible.
- Those who are enrolled in **any** Medicaid Home and Community Based Waiver.
- Those who are eligible for DDSN services in the "At-Risk" category (children three (3) to six (6) years).
- Those who receive Residential Habilitation.
- Those who reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or a Nursing Facility.
- Those in SC Department of Social Services Foster Care or Therapeutic Foster Homes.
- Those residing in a Psychiatric Residential Treatment Facility (PRTF).
- Those families with income above the Income Standards specified in Attachment A may not receive IFS funding for assistance to improve and unsafe, risky, or dangerous situation.

IFS funding will only be made available when needed goods or services cannot be funded by the family, other public agencies or community resources or through other DDSN services/programs. Consideration will be given to all of the resources available to the family, even those resources that cannot directly fund the needed goods or services. Priority will be given to those families with the greatest need.

The policy, in its entirety, can be found on DDSN's website at http://www.ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/734-01-DD%20-%20Revised%20(012615).pdf.

Information about the DDSN Eligible Person

Name: ______________________________ Date of Birth: ______________________________

Address: ____

Who, other than the DDSN eligible person, lives in the home? List each person's relationship to the DDSN eligible person and his/her age (*for example: Mother – age 39; Father –age 40; Sister – age 12*)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

SAMPLE

The DDSN eligible person (check all that apply):

☐ Is Medicaid Eligible?

☐ Receives Children's Personal Care as a State Plan service.
☐ Receives Private Duty Nursing as a State Plan service.

☐ Has Applied for Medicaid: Date of Application: ______________________________
Attends Public or Private School: ☐ Yes ☐ No

☐ Receives Homebound Instruction - If yes, specify instructional time per week: ______________
☐ Is Homeschooled by Family?
☐ Awaiting enrollment in a DDSN-operated Waiver (ID/RD, HASCI, CS, PDD)

☐ Is enrolled/participates in a DHHS-operated Home and Community-based Waiver (SC Choices, Medically Complex Children's Waiver, HIV/AIDS Waiver, Vent)

Is currently employed? ☐ Full-time ☐ Part-time

☐ Receives benefits through the Supplemental Nutritional Assistance Program (SNAP).

☐ Is eligible for Medicare? ☐ Yes ☐ No ☐ Part A ☐ Part B ☐ Part D

What is needed?

What item(s) or service(s) is/are needed by the DDSN eligible person? Describe:

____

____

____

____

Why is/are these item(s) or service(s) needed? Explain:

____

____

____

____

What **other resources** have been attempted or explored to obtain this/these item(s) or service(s)? List:

____

____

____

____

How much is needed? **$**______________________

By **when** (what date) is it needed? ______________________

SAMPLE

Household Income

Information about the monthly household earned and unearned income must be provided in order for the request to be considered. Verification of income must be provided (e.g., payroll check stub, copy of SSI check/deposit, bank statements, Trust Account information, Child Support, etc.). List the sources, amounts and contributor in the chart below and attach/enclose verification documents. **Attach additional pages if needed.**

Income Source	Monthly Amount	Contributed by whom?	Verification Attached Yes/No

Total Monthly Income $___________
(To qualify, Total Monthly Income may not exceed amount specified in the "Monthly Income" column of Attachment A)

Information about the Person Completing Application:

Printed Name: ______________________________

Relationship to the DDSN Eligible Person: ______________________________

Contact Information:

Address: ______________________________

Telephone Number (s): ______________________________ Email Address: ______________________________

I certify that the above information is true and complete. I understand that submitting false information or use of Individual and Family Support Funds for purposes other than as requested may result in termination of assistance and a payback of expended funds to DDSN.

______________________________ Date: ______________________________
Signature of Person Completing Application

Submit Completed Forms to Deborah Mann
Email: dmann@ddsn.sc.gov
Fax: (803) 898-9653

SAMPLE