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

Check if Same as Individual

Street Address: ______________________

Street Address: ______________________

City, State, Zip: ______________________

Family Member's Phone Number: ______________________

Check if Same as Individual

PROVIDER INFORMATION

Provider/ Agency Name: Incommunity Atlanta dba GCSS

Provider/Agency Address

Street Address: 1945 Cliff Valley Way

Street Address: Suite 220

City, State, Zip: Atlanta, GA 30329

Provider/Agency Phone Number: 404-634-4222

Provider/Agency Fax Number: 404-634-1342

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" <u>prior</u> 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