**DEVELOPMENTAL DISABILITIES SERVICES**

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

*(updated 10/06/23)*

**General Information**

Date of Request:

Individual’s Name:

Date of Birth:

Designated Agency:

Specialized Service Agency:

Contact Person:

Requested Start Date of Services:

Funding Decision Letter mailed to:

Name:

Address:

**Eligibility:** (choose one)

[ ]  Intellectual Disability

[ ]  Pervasive Developmental Disorder/Autism Spectrum Disorder

[ ]  Both (ID and ASD)

**New or Existing Applicant:** (choose all that apply)

[ ]  New applicant: did not receive home & community-based services in the past 12 months

[ ]  Existing applicant: 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 all that apply)

[ ]  Aging out of DCF custody (attach current DCF budget)

[ ]  Previously in DCF custody

[ ]  Currently in DCF Custody

[ ] Never in DCF custody

**School Status for Children & Young Adults:** (choose one)

[ ]  Still in school

[ ]  Graduating High School with employment

[ ]  Graduating High School without employment

[ ]  Other: (please explain)

**Children’s Personal Care Services**: (choose one)

**[ ]** Aging Out

**[ ]** Number of Hours

**[ ]** USP – Current Existing

**[ ]** N/A

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).

**[ ]  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 pages 33-35 of System of Care Plan)

**[ ]  3. Preventing Institutionalization** **– Nursing Facilities:** Ongoing, direct supports and/or supervision needed to prevent or end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). Services are legally mandated. (Priority is for children and adults).

**[ ]  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 children and adults)

**[ ]  5. Employment for High School Graduates:** Ongoing, direct supports and/or supervision needed for a youth/young adult to maintain employment. (Priority for adults age 18 through age 26 who have exited high school)

**[ ]  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. (Priority is for adults age 18 and over)

Name:

**Needs Assessment Summary - Factors are 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 [ ]  Reactive Attachment Disorder

[ ]  PTSD [ ]  Anxiety [ ]  Schizophrenia  [ ]  Substance Abuse

[ ]  Other (specify)

**Unpaid 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 [ ]  Refugee Resettlement

[ ]  Natural Supports [ ]  Other (describe) [ ]  Adoption Subsidy

**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) Describe the proposed services and how the proposed services will be utilized to support the unmet needs.

3) Expected outcomes of services – (may be broad or specific)

4) For existing consumers, describe what changes are proposed to be made to existing services, and if no changes are proposed, why not?

Name:       [ ]  Public Safety

Designated Agency: SSA:

**Recommendation by Local Funding Committee**

[ ]  Denied [ ]  Approved Recommended: $

Comments/Changes:

Local Funding Committee Signature:       Date:

**Recommendation by Equity Committee/Public Safety Committee:**

[ ]  Denied [ ]  Approved Recommended: $

Comments/Changes:

Equity/Public Safety Committee Signature:       Date:

**Decision by Department:**

Effective Date:        Continuation Date:       Reconsideration:

Recommended: $

Comments/Changes:

Authorized Signature:       Date: