Pecan Valley MHMR Region
Center Respite / In-Home & Family Support Application FY 09

THE APPLICATION MUST BE COMPLETELY FILLED OUT OR IT WILL NOT BE PROCESSED.

Name:	Social Security Number:
Address (include mailing, if different):	Phone: Work Phone:
County of Residence:	Are you a United States Citizen? ☐YES ☐NO
Date of Birth:	Sex: ☐Female ☐Male

Name of Responsible Party:	Phone:
Address (include mailing, if different):	Work Phone:
Parent: ☐YES ☐NO	Relationship to Applicant:
Legal Guardian: ☐YES ☐NO	

NOTE: The responsible party will be the person receiving the checks or parent or guardian.

PLEASE CHECK DISABILITY TYPE (must submit proof of diagnosis with application):

☐Mental Health ☐PDD
☐Mental Retardation ☐ECI

IF YOU ARE CURRENTLY IN SERVICES WITH PECAN VALLEY MHMR PLEASE COMPLETE THIS SECTION:

Name of Service Coordinator:
Local Case Number:
List the services you are currently receiving from PVMHMR:

PLEASE CHECK THE FOLLOWING SERVICE(S) YOU ARE REQUESTING:

☐ **Respite** $	☐ **Dental** (IHFS only) $	☐ **Counseling** (IHFS only) $
☐ **Behavior Therapy** (IHFS only) $	☐ **Dental Evaluation** (IHFS only) $	☐ **Transportation** (IHFS only) $
☐ **Family Caregiver Training** (IHFS only) $	☐ **Therapy** (IHFS only) ☐ Speech ☐ Equine ☐ Music ☐ ABA ☐ Other _____ $	☐ **Emergency Medication** (IHFS only) $
☐ **Emergency Housing** (One time grant, IHFS only) $	☐ **Diagnostics** (IHFS only) $	☐ **Therapy Equipment** (IHFS only) $
☐ **Mobility Equipment** (IHFS only) $	☐ **Home Modification** (IHFS only) $	☐ **Behavior Coach** (IHFS only) $
☐ **Non Durable Supplies** (IHFS only) $	☐ **Other:** (IHFS only) $	☐ **Other:** (IHFS only) $

Answer ALL of the following questions:

How is the service requested related to current disability and why is this support needed?
(List each service separately.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please indicate the frequency in which the service(s) will be provided:

Service: _____ _____ X per month, or _____ X per fiscal year

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If you are applying for **Respite, Therapy, Counseling, etc.** please answer ALL the following questions (Application will not be processed until you have chosen a provider and submitted the drivers license and/or appropriate credentials):

Service #1: _____

Name of person who will be providing services:	
Address:	
Phone:	Date of Birth (please attach copy of driver's licenses as proof of age; must be over age of 18): _____/_____/_____
Rate per hour: $ _____	Frequency of Service Delivery: _____X per month

Service #2: _____

Name of person who will be providing services:	
Address:	
Phone:	Date of Birth (please attach copy of driver's licenses as proof of age; must be over age of 18): _____/_____/_____
Rate per hour: $_____	Frequency of Service Delivery: _____X per month

Service #3: _____

Name of person who will be providing services:	
Address:	
Phone:	Date of Birth (please attach copy of driver's licenses as proof of age; must be over age of 18): _____/_____/_____
Rate per hour: $_____	Frequency of Service Delivery: _____X per month

If you are applying for **Emergency Housing** (IHFS only) please answer ALL of the following questions:

Where will you be living?	
How much is rent a month?	
Please list and tell the amounts of all deposits required for move:	
How much is the estimated water bill per month?	How much is estimated electric/gas per month?
Total Amount Requested?	

If you are requesting **Dental Assistance** (IHFS only) please submit the following items:

A. Submit a written estimate from a dentist.
   a. List of medications that are prescribed for disability and signed by prescribing physician. The medication must relate to dental condition.
   b. Documentation that medication has side effect that causes dental problems.

OR

B. Provide evidence that the applicant does not posses the cognitive skills needed to maintain good dental health (ability to brush teeth, arrange for dental visits). This evidence must be documented and signed by a licensed professional (LPHA, LPC, LMSW, etc.).

PROOF OF RESIDENCE:

Pecan Valley MHMR Region can only use In Home and Family Support funds for individuals living in one of the 6 counties in which we serve.

In order to be approved for eligibility applicant must submit *one* of the following proofs of residence:

1. Current utility statement
2. Rental agreement
3. Statement of landlord
4. Social Security benefit letter - must be addressed to the applicant and not a payee unless the payee is the parent of a minor child
5. Driver's license - the address on the driver's license must match the address on the applicant's application

Note: *Documentation with a P.O. Box only cannot be used.*

FINANCIAL SECTION:

(Please attach a copy of your previous tax year's 1040, 1040A, or 1040EZ)

PLEASE LIST THE YEARLY AMOUNTS OF INCOME YOU RECEIVE FROM THE FOLLOWING:

Amount		Amount	
	SSI		**Child Support**
	SSDI		**Veterans Administration**
	Social Security		**Rail Road Retirement**
	AFDC		**Employment**
	Other (please specify):		

If you are currently in services with Pecan Valley MHMR Region please attach a copy of financial completed annually by eligibility specialist.

ALTERNATE RESOURCES:

In-Home & Family Support is a resource of last resort, therefore you must show documentation of other resources contacted for assistance before eligibility can be established.

Agency:	**Agency:**
Name of Person you talked to:	**Name of Person you talked to:**
Service requested & Reason For Denial (Include denial letter if you received one):	**Service requested & Reason For Denial (Include denial letter if you received one):**
Phone number:	**Phone number:**

Agency:	**Agency:**
Name of Person you talked to:	**Name of Person you talked to:**
Service requested & Reason For Denial (Include denial letter if you received one):	**Service requested & Reason For Denial (Include denial letter if you received one):**
Phone number:	**Phone number:**

Agency:	**Agency:**
Name of Person you talked to:	**Name of Person you talked to:**
Service requested & Reason For Denial (Include denial letter if you received one):	**Service requested & Reason For Denial (Include denial letter if you received one):**
Phone number:	**Phone number:**

Do you participate in any of the following programs (please check):

	ICF/MR		CLASS		State Hospital
	HCS		MDCP		State School
	TxHmL		Consolidated Waiver Program		State Funded Residential Housing Programs
	Nursing Facility		Deaf-Blind Multiple Disabilities Program		Other 24 Hour residential treatment programs

I understand that I am responsible for providing documentation as required by Pecan Valley MHMR Region to establish eligibility for funds available through the In Home and Family Support Program. I also understand that making statements or representations known to be false and / or solicitation or acceptance of supports for a known ineligible person(s) constitutes a felony of third degree. If any changes in income, living arrangements, property holdings, address or insurance occur, I will notify Pecan Valley MHMR Region within 10 days.

_____ _____

Name of Applicant **Date**

_____ _____

Signature of Applicant or Responsible Party **Date**

AGREEMENTS SECTION

Recipient
Initials Each
Space Below

_____ 1. I agree to provide, **within 30 days** of purchase, original receipts (not copies) for all services and articles purchased with the program's assistance, and that the receipts will:
A. State the total amount of the cost, including co-payment.
B. Include the date the services were provided, purchased, or delivered (which must be after the written plan is approved)
C. Include the vendor's name and identifying information
D. Be marked "paid" by the vendor

_____ 2. I agree to return all funds not used for approved services or articles within 90 days of disbursement or before the end of the fiscal year (August 31), whichever comes first.

_____ 3. I agree to comply with this written plan, and understand that noncompliance may make me ineligible for assistance and make me liable for payment of restitution of funds I received.

_____ 4. I agree that compliance with this written plan may be monitored by my In-Home and Family Support Coordinator or a member of the In-Home and Family Support Committee by:

A. Reviewing all receipts, provider logs, and necessary bids to ensure that they meet program criteria
B. Face-to-face visits
C. Home visits
D. Contacting Provider and/or Vendor
E. Coordinating with legacy TDHS to ensure that IHFS services are not being duplicated
F. Other (specify):_____

_____ 5. I agree to notify the In-Home and Family Support Committee within 10 days after any change in my eligibility status (i.e. diagnosis, residence, financial status, or need) while assistance is ongoing.

_____ 6. I understand that it is a felony for a person to knowingly make or cause the making of a false statement or misrepresentation, or to solicit or accept assistance for which the person knows he or she is not eligible.

_____ 7. I understand that the In-Home and Family Support Committee may increase/decrease the funds requested.

_____ 8. I understand that this written plan is valid only in the fiscal year (Sept. 1 thru Aug. 31) for which it was developed, and that it becomes a part of my treatment plan if I receive other nonresidential services from Pecan Valley MHMR.

_____ 9. I understand that the grant amount approved is the dollar amount I am eligible to receive over the course of the fiscal year. This amount may be distributed by payments of monthly installments, or in certain circumstances a single check.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Preparing Staff Person Date