Bright Start LLC
Helping families today, reach goals for tomorrow

Application for Family Support Funds

Consumer Name:		DOB/Age:	
Parent/Legal Guardian:		Address:	
EI/CM Name:		EI/CM Supervisor:	
DDSN Eligibility: ☐ ID ☐ RD ☐ Autism	At risk? ☐ Yes ☐ No Time limited? ☐ Yes ☐ No If at-risk or time-limited, provide eligibility expiration date:_____	Date of Request:	

Is this person enrolled in any Medicaid Home and Community Based Waiver? (IDRD, PDD, CSW, MCC, CCW)	☐ Yes ☐ No
Does this person receive residential habilitation services?	☐ Yes ☐ No
Does this person reside in an ICF/IID or Nursing Home?	☐ Yes ☐ No
Is this person in foster care or in a therapeutic foster care home?	☐ Yes ☐ No
Does this person receive State Funded Community Supports?	☐ Yes ☐ No
Does the family's income exceed the income standards specified in Attachment A?	☐ Yes ☐ No

*If yes is checked for any of the above questions, the person is not eligible to receive respite.

Answer the following questions about the person applying for respite:

Medicaid Eligible?	☐ Yes ☐ No	If not Medicaid. elig., has this person applied? Date applied: _____	☐ Yes ☐ No
Receiving Children's Personal Care Aide Services?	☐ Yes ☐ No	Receiving homebound school services? If so, how many hours are provided each week?	☐ Yes ☐ No
Receives Private Duty Nursing as a State Plan Service?	☐ Yes ☐ No	Receiving homeschool services?	☐ Yes ☐ No
Receiving RBHS?	☐ Yes ☐ No	Enrolled in a day care, adult day program, adult day health care or employment program?	☐ Yes ☐ No
Attending school?	☐ Yes ☐ No	On the waiting list for a DDSN Waiver?	☐ Yes ☐ No
Receive benefits through the Supplemental Nutritional Assistant Program (SNAP)?	☐ Yes ☐ No	Eligible for Medicare?	☐ Yes ☐ No ☐ A ☐ B ☐ D

List others who live in the home and their age (i.e. mother, 25, sister, 24 months)

Relationship	Age	Relationship	Age

What item or service is needed? Describe.	
Why is the item or service needed? Explain?	
What other resources have been attempted or explored to obtain this item or services? List: (DO NOT LEAVE THIS SECTION BLANK)	
How much is needed?	By what date is it needed?

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

_____ _____

Signature of Person Completing Application Date:

****

(To be completed by Management only)

☐ Approved

Amount approved:	

☐ Denied (Written notification of denial with the appeal process shall be provided by the EI/CM to the family. This form is for internal use only)

Reason for denial:

_____ _____

Signature of Executive Director Date

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
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

Total Monthly Income: $_____

If applicant receives SSI, indicate how the SSI is used each month: _____

_____

_____

(To qualify, total monthly income may not exceed amount specified in the "monthly income" column of attachment A)

SC Department of Disabilities and Special Needs

Income Standards for Family Support Funds

Family Size	Monthly Gross Income	Eligible for Funds	Family Size	Monthly Gross Income	Eligible for Funds
1	$0 - $1,456	☐ Yes	9	$0 - $5,519	☐ Yes
1	$1,460 +	☐ No	9	$5,5,20 +	☐ No
2	$0 - $1,966	☐ Yes	10	$0 - $6,026	☐ Yes
2	$1,967 +	☐ No	10	$6,027 +	☐ No
3	$0 – $2,474	☐ Yes	11	$0 – $6,534	☐ Yes
3	$2,475 +	☐ No	11	$6,535 +	☐ No
4	$0 – $2,981	☐ Yes	12	$0 – $7,041	☐ Yes
4	$2,982 +	☐ No	12	$7,042 +	☐ No
5	$0 – $3,489	☐ Yes	13	$0 – $7,549	☐ Yes
5	$3,490 +	☐ No	13	$7,550 +	☐ No
6	$0 – $3,996	☐ Yes	14	$0 – $8,056	☐ Yes
6	$3,997 +	☐ No	14	$8,057 +	☐ No
7	$0 – $4,504	☐ Yes	15	$0 – $8,564	☐ Yes
7	$4,505 +	☐ No	15	$8,565 +	☐ No
8	$0 – $5,011	☐ Yes	16	$0 – $9,071	☐ Yes
8	$5,012 +	☐ No	16	$9,072 +	☐ No

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Application for Respite Funds

Consumer Name:		DOB/Age:	
Parent/Legal Guardian:		Address:	
EI/CM Name:		EI/CM Supervisor:	
DDSN Eligibility: ☐ ID ☐ RD ☐ Autism	At risk? ☐ Yes ☐ No Time limited? ☐ Yes ☐ No If at-risk or time-limited, provide eligibility expiration date:_____	Date of Request:	

Is this person enrolled in any Medicaid Home and Community Based Waiver? (IDRD, PDD, CSW, MCC, CCW)	☐ Yes ☐ No
Does this person receive residential habilitation services?	☐ Yes ☐ No
Does this person reside in an ICF/IID or Nursing Home?	☐ Yes ☐ No
Is this person in foster care or in a therapeutic foster care home?	☐ Yes ☐ No
Does this person receive State Funded Community Supports?	☐ Yes ☐ No

*If yes is checked for any of the above questions, the person is not eligible to receive respite.

Answer the following questions about the person applying for respite:

Medicaid Eligible?	☐ Yes ☐ No	If not Medicaid. elig., has this person applied? Date applied: _____	☐ Yes ☐ No ☐ NA
Receiving Children's Personal Care Aide Services? If yes, list amount and frequency. _____	☐ Yes ☐ No	Receiving homebound school services? If so, how many hours are provided each week?	☐ Yes ☐ No
Receives Private Duty Nursing as a State Plan Service? If yes, list amount and frequency. _____	☐ Yes ☐ No	Receiving homeschool services?	☐ Yes ☐ No
Receiving RBHS?	☐ Yes ☐ No	Enrolled in a day care, adult day program, adult day health care or employment program?	☐ Yes ☐ No
Attending school?	☐ Yes ☐ No	On the waiting list for a DDSN Waiver?	☐ Yes ☐ No

Engaging in inappropriate disruptive behavior on a daily basis (hitting, kicking, running away, smearing feces, eating non-food items, etc. ?	☐ Yes ☐ No	Have a complex medical condition or disabilities that makes care difficult (diaper changes/incontinence care, hands on feeding, etc.)	☐ Yes ☐ No
If answered yes to any of the above questions in this section, please explain:			

(attach additional information or records if needed)

Who is the primary caregiver for the applicant?

Name:		Relationship/age:	

Who provides care when the primary caregiver is not available?

Name:		Relationship/age:	
Name:		Relationship/age:	
Name:		Relationship/age:	

List others who live in the home and their age (i.e. mother, 25, sister, 24 months)

Relationship	Age	Relationship	Age

Has the applicant received respite in the past 6 months? ☐ Yes ☐ No

If yes, how often was respite received? _____

Additional justification:

Request for respite funding:

☐ **To be provided one-time during the temporary absence of the primary caregiver.**

Number of hours requested:	
Dates of request:	

Explain why the caregiver will be unavailable:

☐ **To be provided monthly.**

Number of hours requested per month:	
Duration of Request (i.e. 3 months, March, April, May, etc.): (cannot exceed 6 months, cannot cross over contract period which ends June 30)	

Amount Requested:

Total number of hours:	
Hourly rate:	
Total:	

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

_____ _____

Signature of Person Completing Application Date:

(To be completed by Management only)

☐ **Approved**

Amount approved:	

☐ **Denied (Written notification of denial with the appeal process shall be provided by the EI/CM to the family. This form is for internal use only)**

Reason for denial:

_____ _____

Signature of Executive Director Date

Individual Family Support and Respite (IFS/R)

State Funding Guidelines

IFS/R funds are used to assist families in caring for their family member with special needs. DDSN issues funds to providers across to state to distribute according to the established guidelines and directive set forth by DDSN. Requests for funds may be made to Bright Start for those who are currently served by our agency. Funds are limited and each request will receive careful review and consideration.

The purpose of Individual Family Support and Respite funding

- Provide assistance to families in caring for a DDSN eligible person
- Assist families who are providing direct, hands-on care and supervision
- Avoid unsafe, risky or dangerous situations
- Assist consumers and families who can care for their family member at home but incur additional expenses due to the disability
- Should be used for needs that are not incurred routinely by families with non-disabled individuals
- Funding is intended to be limited, one-time or short-term and should not be ongoing
- IFS/R is not an entitlement program or a general public assistance benefit
- IFS/R is not intended to be used for typical expenses that are routinely incurred by families such as rent, utilities, childcare/babysitting for children under age 12, etc.

Eligibility:

IFS/R funding shall be available to:

- Those who are DDSN eligible – all ages
- Those who are eligible for DDSN services in the "At-Risk" category ages 0-3 are eligible (Those served at-risk ages 3-6 are not eligible)
- Those who are NOT enrolled in any Medicaid Home and Community Based Waiver.
- Those who do not receive Residential Habilitation.

- Those who do not reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or a Nursing Facility.
- Those who are not in SC Department of Social Services Foster Care or Therapeutic Foster Homes.
- Those who do not reside in a Psychiatric Residential Treatment Facility (PRTF).
- Those who do not receive State Funded Community Supports
- Those families whose income is at or above the threshold specified in Attachment A – Income Standards

Family Support Funds

- Based on the income of the consumer and family members residing in the same home as the consumer. Please see attached income guidelines.
- Must provide a current pay stub or other means of verifying both earned and unearned income for ALL household members (SSI, Child Support, etc.)
- Provide information on how the consumer's social security or other unearned income is used
- Exceptions to the income guidelines can occur when the person does not meet the income criteria but has significant expenditures related to the person's disability

Respite:

- Respite requests DO NOT require review of income.

***If a family receives more than $600 in a calendar year, an IRS Form 1099 will be issued.

Refer to SCDDSN Directive 734-01-DD for more information.
http://www.ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/734-01-DD%20-%20Revised%20(092313).pdf