|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Agency Name | | | Agency Address | | | | Phone # | | Fax # | |
|  | | |  | | | |  | |  | |
| Name of Person Supported: | | | | Social Security Number: | | | Date of Birth: | | | |
| Name of Primary Family Member: | | | | Phone Number: | | | Email Address: | | | |
| Client ID# (optional): | | | | Reason for the Need for Support: | | | | | | |
| **Services To Be Provided \*Please check all which apply** | | | | | | | | | | |
| Before/After Care |  | Health Related | | |  | Service Animals | | | |  |
| Behavior Services |  | Home Modifications | | |  | Specialized Equipment & Repair and/or Maintenance | | | |  |
| Day Care |  | Homemaker Services | | |  | Specialized Nutrition, Clothing, and/or Supplies | | | |  |
| Education/Home School/Tuition |  | Nursing/Nurse’s Aide | | |  | Training | | | |  |
| Emergency Living Expenses |  | Personal Assistance | | |  | Transportation | | | |  |
| Family Counseling |  | Recreation/Summer Camp | | |  | Vehicular Modifications | | | |  |
| Funeral/End-of-Life Costs |  | Respite | | |  | Other: | | | |  |
| **TOTAL Plan Amount not to exceed:** | | | | | | | | **$** | | |

Frequency/Duration Method of Payment for Service:

*\*Categories may be changed by recipient as needed as long as the maximum financial commitment is not exceeded. Program participation cannot be guaranteed beyond this contract year. The Family Support Program is funded under an agreement with the State of Tennessee.*

**AGREEMENT**

The Family Support Program is not responsible for payment of services exceeding the plan allotment. The person who has signed below has participated in the development of this plan and indicates their agreement to the plan by their signature.

The following must be received in the Family Support Office in order to receive services:

1. The signed copy of the Family Support Service Plan and Title VI “Discrimination is Prohibited” Form,
2. Verification of address,
3. Verification of disability and citizenship (if requested).

***By signing and dating this form, I, the person supported or legal representative, indicate that all of the information above is true and accurate. Furthermore, I understand providing invalid, inaccurate or incomplete information may result in denial of a claim, disenrollment from the program and/or criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.***

Signature of Person Supported or Family Signature of Agency Representative

Date Signed Date Signed

|  |  |  |
| --- | --- | --- |
| * Regular Plan ☐ Emergency Plan | Approved by the Local Council | *The Agency complies with Title VI, which prohibits discrimination on the basis of race, color, or nationality.* |