United Cerebral Palsy of Middle Tennessee
Rutherford County
P.O. Box 10996
Murfreesboro, TN 37129
Phone: 615-796-3341
Fax: 615-369-3085
Email: Jo_VerMulm@ucpnashville.org
Website: www.ucpmidtn.org

Dear Applicant:

Thank you for your interest in the Rutherford County Family Support Program. The fund is made available through a grant from the State of Tennessee, and as such, certain eligibility requirements apply. Before you can be considered for assistance you must provide all of the information required in the application package.

Include all documents requested and mail to us at the address above. Please make sure you have the appropriate postage on the envelope. You may also fax your materials to me at 615-369-3085. Once we have all the completed materials in hand, your application will go before the Rutherford County Family Support Council at their next scheduled meeting. This council makes determinations as follows:

1. Eligible – Allocation Amount Determined
2. Eligible – Waiting List
3. Not Eligible/Services Denied

Please be aware that we are not able to fund all requests. Each year, the Family Support Council develops a list of priorities that are utilized in consideration of applications. The determination regarding whether your request is appropriate for the program is made after eligibility review. Then, the Family Support Council determines the amount, if any, that we can allocate for your services. There is no guarantee that we will have funding available for all eligible applicants. Family Support is not an entitlement program.

Please feel free to contact me should you have other questions.

Sincerely,

Jo Ver Mulm

Rutherford County Family Support Coordinator

2017-2018 Rutherford County Family Support Program Application

Date Application Rec'd (office use only) _____

Name of Family Member with a Severe or Developmental Disability _____ age_____

Social Security #_____ Date of Birth_____

Name of Primary Family Member(s) to contact regarding this application if other than the person named above _____ relation _____

Address_____ Phone_____

City, State, Zip_____ Phone_____

County_____ Email Address_____

Preferred Method of Contact (circle) Phone or Email

☐ Lives Alone ☐ Lives with Family ☐ Lives in a Supported Setting (nursing home, group home, foster care, institution)

Reason you are applying for Family Support Services (Describe your disability and Include information on the impact of the disability on your family.)

_____

_____

_____

_____

_____

_____

_____

Potential Support Services Needed/Requested:

☐ Before/After Care	☐ Health Related	☐ Respite	☐ Recreation/Summer Camp
☐ Behavior Services	☐ Home Modifications	☐ Specialized Equipment & Repair/Maintenance	☐ Vehicle Modifications
☐ Conservatorship	☐ Homemaker Services	☐ Specialized Nutrition/ Clothing Supplies	Other: _____
☐ Day Care	☐ Nursing/Nurses Aide	☐ Training	Other: _____
☐ Family Counseling	☐ Personal Assistance	☐ Transportation/Medical Travel Per Diem	

Be sure and complete the reverse side of the application.

Is the Individual or Family Currently Receiving Other Services (Check all that apply)?

☐ Adoption Assistance	☐ Medicaid	☐ Residential Services	☐ TennCare
☐ CHOICES Waiver	☐ Medicare	☐ Social Security Income	☐ Vocational Rehabilitation (VR)
☐ DIDD Waivers	☐ Nursing Services	☐ Social Security Disability Income	☐ PACE
☐ Food Stamps	☐ OPTIONS Program	☐ Supported Living	☐ Other: _____
☐ Foster Care	☐ Private Insurance	☐ Tenn. Early Intervention System	☐ Other: _____

To comply with Title IV, the following information is requested:
☐ Caucasian ☐ African-American ☐ Hispanic ☐ Other _____
☐ Male ☐ Female

Primary Disability – Check which of the following major disability categories is most relevant to the applicant as a primary diagnosis. If a second disability is applicable please indicate that by placing a '2" next to it:

☐ Autism
☐ Cerebral Palsy
☐ Deaf and/or Blind
☐ Health Impairment
☐ Traumatic Brain Injury
☐ Other_____
☐ Intellectual Disability
☐ Neurological Impairment
☐ Orthopedic Impairment/ Physical Disability
☐ Spinal Cord Injury
☐ Developmental Delay (Birth - 8 years old)

At what age did the primary disability occur?

☐ Prior to age 22
☐ At age 22 or after

Is anyone else in your family/household applying for or currently receiving Family Support? ☐ YES ☐ NO

If yes, please list name(s)_____

By signing and dating this application, I, the applicant or legal representative indicate that all of the information above is correct.

_____ _____
Signature of Applicant or Legal Representative **Date**

Return this application with the required documentation by mail, fax or email to:

UCP/Family Support
attn: Jo Ver Mulm
P.O. Box 10996
Murfreesboro, TN 37129
Fax: 615-369-3085
jo_vermulm@ucpnashville.org

Functional Limitations

Name of Applicant: _____ Date_____

Name of Person Completing this Form on behalf of Applicant: _____

The Family Support Program is established to provide services to persons with specific functional limitations. Please complete the following information related to functional limitations of the individual applying for services. NOTE: Do NOT simply check "Child/Does not Apply" on every line. Think about how your child compares to typically developing peers of the same age. This options should only be selected in questions (like "ability to earn a living") where the answer is unknown. **Answers from this form alone do not determine eligibility for the Family Support Program.**

Physical Limitations	**Yes**	**No**	**Child/Does not Apply**
Able to walk without supports or assistance?	☐	☐	☐
Able to sit up without supports?	☐	☐	☐
Able to transition from chair to standing or from bed to standing position unassisted?	☐	☐	☐
Able to use arms and hands?	☐	☐	☐
Able to dress without assistance?	☐	☐	☐
Able to eat without assistance?	☐	☐	☐
Able to go to the bathroom and bathe without assistance?	☐	☐	☐
Able to see clearly enough to read? (If applicant wears correctives lens, can they see clearly when wearing glasses, contacts etc.?)	☐	☐	☐
Able to hear without a hearing aid?	☐	☐	☐
Able to speak clearly enough to be understood by others?	☐	☐	☐

Behavioral Limitations	**Yes**	**No**	**Child/Does not Apply**
Able to behave in a generally socially acceptable manner without guidance and supervision?	☐	☐	☐
Able to self-supervise? (i.e., can be left alone for long periods of time)	☐	☐	☐
Able to self-regulate emotions/emotional behavior?	☐	☐	☐
Able to comprehend and follow simple directions?	☐	☐	☐

Life Skills Limitations	**Yes**	**No**	**Child/Does not Apply**
Able to earn a living or care for others?	☐	☐	☐
Able to make critical decisions and manage appointments for self?	☐	☐	☐
Able to drive a car?	☐	☐	☐
Able to conduct personal finances without assistance?	☐	☐	☐

See reverse side:

Please provide other information below or on a separate document that may be helpful in ascertaining the level of functional disability this individual has:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Enclosure Checklist

Use this checklist to ensure all required items are enclosed. Your application cannot be considered without all required information.

[ ] **Family Support Program Application**: Completed, signed and dated.

[ ] **Updated Documentation of Disability**: A recent letter or statement from your physician that describes your disability explains specifically how your life activities are limited. Statements obtained from urgent care/walk-in clinics will not be accepted. Eligibility for the Family Support Program is **not** based on the receipt of Social Security Disability benefits.

[ ] **Documentation of Residency in Rutherford County**: In order to provide funding for Family Support services designated for Rutherford County, we must have documentation that the applicant lives in Rutherford County. Acceptable documentation would include copy of any of the following: recent (within the last 60 days) utility statement or government document with the name of the applicant (or applicant's head of household) and the applicant's street/home address. Please note: Post Office Box addresses are not acceptable evidence of residency, neither are bank or credit card statements.

[ ] **Proof of U.S. Citizenship**:

Examples of Documentation that can be used to verify citizenship:

- *Birth Certificate from USA, District of Columbia, Puerto Rico, Guam, Virgin Islands, or the Northern Mariana Islands*
- *Born abroad to U.S. Citizens and provide Consular Report of Birth Abroad*
- *Certificate of Citizenship*
- *Certificate of Naturalization*
- *National from American Samoa or Wain's Island*
- *US Passport or US Passport Card*
- *Certification of Birth Abroad*

Examples of Documentation that CANNOT be used to verify citizenship:

- *Adoption Decree or Adoption Court Documents*
- *DIDD Verification*
- *Driver's License*
- *Green Card*
- *Health Records (Immunization)*
- *Medicaid/Medicare Card*
- *Parent's Proof of Citizenship*
- *Permanent Resident Card*
- *Social Security Card*
- *SSA/SSI Statement or Letter (if there is a letter after the SS# that is definitely related to a disability it can be used – send supporting documentation that the letter is disability related). Must be verified by DIDD Central Office before services are approved.*