|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Request**       | **Case Manager**       | **CM Phone #**       |  |
| **Individual’s Name**       | **DDS #**       |
| **Individual’s Address**       |
| **Phone #**       | **D.O.B.**       | **Gender** [ ]  Male [ ]  Female |

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| Please indicate the individual, parent, guardian, agency or business**\*** that will receive and manage the grant funding.**Send Payment to Payee Name**       |
| **Address**      **[ ]  New Address** [ ]  **Mail paperwork** |
| **Phone #**       | **Email Address**       | **Payee SS # or FEIN #**       |
| **Return Check to DDS** | **Yes** **[ ]**  | **Reason:**       |

**\*Note:** Individual and family grants can only be paid to private agency payees or businesses after the service is provided and after the private agency payee or business sends an invoice.

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| **Nature of Disability**      **Disability Related Costs** (Choose one or more services or items and then describe how their costs are not reimbursable from other funding sources, such as insurance or entitlement programs, and how the service or the item relates to the individual’s disabilty) |
| **Description of services or supports requested**       |
| **Total Grant Request Amount $**       |

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| **Would a partial grant be helpful?** Yes [ ]  No [ ]  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the family or individual currently receive other services or supports?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Services or Supports  | **Yes** | **No** | **Amount** | **Comments** |
| Enrolled in Medicaid Waiver | [ ]  | [ ]  | N/A |       |
| Title 19 (T19) | [ ]  | [ ]  | N/A |       |
| SSI, SSDI (whichever is applicable) | [ ]  | [ ]  | $      /month |       |
| Day Services | [ ]  | [ ]  | $      /year |       |
| Residential Services | [ ]  | [ ]  | $      /year |       |
| Other (Community First Choice (CFC), Home Health Agency (HHA), etc.) | [ ]  | [ ]  | (Please indicate services or supports and frequency)      |

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| --- | --- | --- |
| **Individual’s Name**   | **DDS #**   | **Date**   |
| **Residential Category** | [ ] Emergency | [ ] Urgent | [ ] Future Need | [ ] N/A | LON (Res) Composite      (if applicable) Behavior       |

Use the following checklist to determine whether the individual has a low, moderate, or high need for grant funding:

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| --- | --- | --- |
| **Expressed Need**1. Individual or family requests occasional support related to the disability.
2. Individual or family requests regular support related to the disability.
3. Individual or family requests frequent and intensive support related to the disability.

 **Individual’s Support Needs**1. Individual needs minimal care or support.
2. Individual has medical, behavioral, or physical needs that require routine attention and support.
3. Individual has extensive medical, behavioral, or physical needs that require significant attention and support.

 **Household Responsibilities**Identify Number in Household 1. Two or more family members able to provide support to individual and no other dependents.
2. Two or more family members able to provide support and one or more other dependents.
3. One family member able to provide support and no other dependents (or)
4. Individual has no support in the home.
5. Individual or single caregiver has one additional dependent living in the home.
6. Individual or single caregiver has more than one additional dependent living in the home.
 |  **Other Sources of Support**1. Individual or family has regular access to assistance and support from other family members, extended family, friends, neighbors, and other agency support such as extended school, home health care, DPH, DCF, or DSS community-based services.
2. Individual or family has occasional access to assistance and support from other family members, neighbors, friends, and community organizations or other agency support such as school, home health care, DPH, DCF, or DSS community-based services.
3. Individual or family has no access to assistance and support from other family members, extended family, neighbors or other agency support such as school, home health care, DPH, DCF, or DSS community-based services.

 **Household Income Level**1. Household income $101,500 or more
2. Household income $82,801to $101,500
3. Household income $57,601to $82,800
4. Household income $36,001to $57,600
5. Household income $36,000 or less
 |  **DDS Supports**1. Individual or family has regular access to DDS services or supports, which include Individual & Family Grant, respite supports, or full-time day services.
2. Individual or family receives occasional respite supports or part-time day services.
3. Individual or family receives no other DDS services or supports.

 **Individual’s or Caregiver’s Age/Health**(For this section: “Individual” refers only to those individuals who live independently)1. Individual or Caregiver is in good health.
2. Individual or Caregiver is age 65 or over and in good health.
3. Individual or Caregiver is in poor health.
4. Individual or Caregiver is age 65 or over and in poor health.

**0 Total Points** **(calculated automatically)** 4 - 11 Low12 - 17 Moderate18 - 23 High |

|  |  |  |  |
| --- | --- | --- | --- |
| **GRANT AUTHORIZATION**  | **APPROVED** **[ ]**  | **DENIED** **[ ]**  | **MODIFIED** **[ ]**  |
| **GRANT AMOUNT APPROVED** | **$**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- |
| **Comments**       |

**Grant Manager’s or Grant Manager Designee’s Signature**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**      \_\_\_\_\_\_\_\_\_\_\_\_