West Virginia State Family Support Application

Thank you for applying for funds through the West Virginia Family Support Program. Please note that Family Support funds are intended to be used as a last resort and you should utilize other programs before applying for this program. Please print clearly and fill out all THREE pages, including your signature and initials at the end of the application. Any application not completed in full will not be considered at the next committee meeting. Please attach estimates for the items you are trying to purchase. Please send to the Behavioral Health Center in your county. Thank you.

APPLICANT'S NAME: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____ COUNTY: _____

_____ OWN OR RENT? _____

PHONE NUMBER: _____ DATE OF APPLICATION: _____/_____/_____

SSN: _____-_____-_____ HAVE YOU BEEN APPROVED BEFORE FOR FUNDS? _____

DIAGNOSIS WITH AGE OF ONSET (PLEASE ATTACH DOCUMENTATION): _____

_____

_____

ARE YOU WORKING WITH ANOTHER CASE MANAGER OR AGENCY? IF SO, WHO? _____

_____

WHO REFERRED YOU TO THE FAMILY SUPPORT PROGRAM? _____

WHAT ARE YOU REQUESTING? _____

_____

_____

FULL COST: _____ WHAT CAN YOU CONTRIBUTE? _____
IF YOU ARE NOT FULLY FUNDED, WILL YOU BE ABLE TO MEET THIS NEED ANOTHER WAY? ___

_____

HOW WILL THIS BENEFIT YOUR FAMILY? PLEASE ATTACH ADDITIONAL PAGES IF NECESSARY.

_____

_____

PROGRAMS ALREADY EXPLORED

PROGRAM	***YES/NO, APPROVED/DENIED***
SOCIAL SECURITY / DISABILITY	
TITLE XIX / WAIVER	
ENVIRONMENTAL ACCESS	
PRIVATE INSURANCE	
MEDICAID / MEDICARE	
WV CHIPS	
WV BIRTH TO THREE	
CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM	
CHILDREN WITH SPECIAL HEALTHCARE NEEDS	
NON-EMERGENCY MEDICAL TRANSPORTATION REIMBURSEMENT (DHHR)	
WV WORKS / TAN-F (RELATED TO CHILD SUPPORT, DHHR)	
WIC (DHHR)	
FOOD STAMPS (DHHR)	
OTHER: _____	
OTHER: _____	
OTHER: _____	

PLEASE LIST ANY ATTACHMENTS TO THIS APPLICATION SO THE COMMITTEE CONSIDERS ALL INFORMATION FOR YOUR REQUEST. _____

_____

BY SIGNING THIS APPLICATION, YOU AGREE THAT ALL OF THE INFORMATION PROVIDED IS ACCURATE AND THE APPLICATION IS COMPLETE.

_____

PRINTED NAME / RELATIONSHIP TO APPLICANT

_____

SIGNATURE / DATE

PLEASE READ THE FOLLOWING INFORMATION AND INITIAL BY EACH TO INDICATE THAT YOU HAVE READ AND UNDERSTAND THEM IN FULL. THANK YOU.

_____ 1. ***APPLICATIONS ARE PRESENTED TO THE COMMITTEE ONLY BY AN ID NUMBER TO PRESERVE CONFIDENTIALITY.***

_____ 2. ***FAMILY SUPPORT FUNDS ARE NOT GUARANTEED TO BE AVAILABLE. YOU MAY RECEIVE ALL, PART, OR NONE OF THE FUNDS REQUESTED.***

_____ 3. ***SPECIFIC GUIDELINES REGARDING DISTRIBUTION OF FUNDS MAY VARY FROM AGENCY TO AGENCY WITHIN THE STATE.***

_____ 4. ***BY INITIALING, YOU GIVE PERMISSION FO THE FAMILY SUPPORT COORDINATOR TO CONTACT YOU, THE PERSON RECEIVING THE FUNDS, THE THERAPIST, OR THE PERSON REQUESTING THE FUNDS TO GATHER MORE INFORMATION RELEVENT TO THE APPLICATION PROCESS.***

_____ 5. ***IF APPLICABLE, IF YOU CHANGE THE REASON FOR NEEDING THE FUNDS, YOU MUST FIRST CONTACT THE FAMILY SUPPORT COORDINATOR FOR PERMISSION FIRST. YOU MAY BE REQUIRED TO REAPPLY, AND THE ITEM REQUESTED MAY BE LISTED ON THE MEMO PORTION OF THE CHECK AS A RECORD.***

_____ 6. ***IF APPLICABLE, YOU WILL RECEIVE A LETTER IN THE MAIL REGARDING YOUR FUNDS. YOU MUST RETURN THAT LETTER WITHIN 30 DAYS OR YOUR MONEY WILL BE RETURNED TO THE COMMITTEE FOR ANOTHER APPLICANT.***

_____ 7. ***IF APPLICABLE, YOU MUST KEEP RECEIPTS FOR ALL MONEY SPENT AFTER RECEIVING FUNDS AND TURN THEM IN TO THE FAMILY SUPPORT COORDINATOR WITHIN 30 DAYS. PLEASE SUBMIT COPIES OF RECEIPTS, NOT ORIGINALS.***

_____ 8. ***FAMILY SUPPORT FUNDS ARE NOT AVAILABLE TO REIMBURSE FUNDS ALREADY SPENT BY THE FAMILY.***

Please send to the Behavioral Health Center in your county. Thanks

FOR OFFICE USE ONLY

DATE OF MEETING: _____/_____/_____ ***ID NUMBER: _____***
FUNDS REQUESTED: _____ ***FUNDS ALLOCATED: _____***
DATE RECEIPS REC'D: _____/_____/_____ ***REFERRALS MADE: _____***
_____

APPROVED / DENIED