DEPARTMENT OF AGING & DISABILITIES
DEVELOPMENTAL DISABILITY ORGANIZATION
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ANNETTE GRAHAM, EXECUTIVE DIRECTOR • SEDGWICKCOUNTY.ORG
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Family Support Request

$3,500 maximum allocation

Date:

Name:

DOB:

SSN:

Tier:

Child Assessment Score:

TCM & Agency Name:

TCM Phone:

Current Funding

Day: None

Residential: None

Personal Care Services: None

Specialized Medical: None

Medicaid? Yes ☐ No ☐

Private Insurance? Yes ☐ No ☐

Insurance Provider/MCO, if applicable:

Amount Requested:

Justification for Request: (provide an explanation including what is being requested, information about the individual's IDD needs, and why supports are needed during the requested times. If more than one item/support is requested, please indicate priority.)

Click here to go to the Funding Committee Guide

Please list other resources which have been explored and exhausted prior to making this request (include any Value Added Benefits from the MCO, extended school year opportunities, scholarship(s) awarded, current waivers and natural supports available).

Revised: 09/27/2024

If requesting summer camp, please complete the following:

Name of Camp: Admissions Contact Person

What is the staffing ratio:

Eligible for extended school year (ESY)? Yes No N/A

Plans for attending ESY (dates and times):

If requesting incontinence protection (briefs/diapers), please indicate the number of product(s) used in a typical month:

Item - Brand Name/Description	Size	Amount/Package Size	Item Cost

Support Schedule

If requesting staff supports or personal care, explain what days/times supports are being requested.

Family Support Request - Calculations

Complete the monthly chart with the number of hours per month being requested.

Month	Week 1 Su	M	Tu	W	Th	Fr	Sa	Total	Week 2 Su	M	Tu	W	Th	Fr	Sa	Total
January								0.00								0.00
February								0.00								0.00
March								0.00								0.00
April								0.00								0.00
May								0.00								0.00
June								0.00								0.00
July								0.00								0.00
August								0.00								0.00
September								0.00								0.00
October								0.00								0.00
November								0.00								0.00
December								0.00								0.00

	Week 3 Su	M	Tu	W	Th	Fr	Sa	Total	Week 4 Su	M	Tu	W	Th	Fr	Sa	Total
January								0.00								0.00
February								0.00								0.00
March								0.00								0.00
April								0.00								0.00
May								0.00								0.00
June								0.00								0.00
July								0.00								0.00
August								0.00								0.00
September								0.00								0.00
October								0.00								0.00
November								0.00								0.00
December								0.00								0.00

	Week 5 Su	M	Tu	W	Th	Fr	Sa	Total	Monthly Total	Agency Directed	Self Directed (+ 170.74)
January								0.00	0.00	$ 0.00	$ 0.00
February								0.00	0.00	$ 0.00	$ 0.00
March								0.00	0.00	$ 0.00	$ 0.00
April								0.00	0.00	$ 0.00	$ 0.00
May								0.00	0.00	$ 0.00	$ 0.00
June								0.00	0.00	$ 0.00	$ 0.00
July								0.00	0.00	$ 0.00	$ 0.00
August								0.00	0.00	$ 0.00	$ 0.00
September								0.00	0.00	$ 0.00	$ 0.00
October								0.00	0.00	$ 0.00	$ 0.00
November								0.00	0.00	$ 0.00	$ 0.00
December								0.00	0.00	$ 0.00	$ 0.00
								Annual Total		$ 0.00	$ 0.00

Household Members

Persons living in the home and relationship to individual (include additional member on another sheet, if needed):

Name	Relationship	Age	Employed	Receives IDD Services

If requesting staff supports or personal care, please fill out the family schedule below by documenting all activities in an average week for all members of the household (14 years or older).

Monday			
Relationship to Individual	Type of Activity	From	To

Tuesday			
Relationship to Individual	Type of Activity	From	To

Wednesday			
Relationship to Individual	Type of Activity	From	To

Thursday			
Relationship to Individual	Type of Activity	From	To

Friday			
Relationship to Individual	Type of Activity	From	To

Saturday			
Relationship to Individual	Type of Activity	From	To

Sunday			
Relationship to Individual	Type of Activity	From	To

Additional Comments Related to Scheduling

Revised: 09/27/2024

Household Income

Provide Income information for all members of the household:

Monthly Gross Income (provide proof of all documented income)			
SSI/SSDI		Employment	
Family Support/Subsidy		Alimony/Child Support	
General Assistance		Trust Fund/Adoption Subsidy	
Temporary Aid for Needy Families (TANF)		Food Stamps (Vision Card)	
Other (please explain below)		Average Monthly Income	$ 0.00
		Average Annual Income	$ 0.00

If receiving SSI/SSDI, who is the individual's payee?

If an exception to the SCDDO Sliding Fee Scale is needed due to extenuating circumstances, please explain below and provide any supporting documentation (subject to SCDDO Director's approval).

Supporting Documentation (to be included with the request form)

1. Income verification for all types of household income listed above for all household members	☐ Yes	☐ N/A
2. Doctor's orders / professional recommendation	☐ Yes	☐ N/A
3. Two bids for each item requested (except incontinence supplies)	☐ Yes	☐ N/A
4. All support plans with signature pages	☐ Yes	☐ N/A
5. Approval/Acceptance letter from camp	☐ Yes	☐ N/A
6. If requesting camp, the current Individualized Education Plan	☐ Yes	☐ N/A
7. Other:	☐ Yes	☐ N/A
8. Other:	☐ Yes	☐ N/A
9. Other:	☐ Yes	☐ N/A

Family Support Request Form
Signature Page

The SCDDO requires the individual to use an affiliated agency, Self-Directed provider and/or licensed childcare provider for all staff support and personal care services. Please indicate the name of the provider and which type of service is being requested.

Agency/Licensed Provider Name:

☐ Agency-Directed

☐ Self-Directed (if selected, the monthly Financial Management Services fee will be deducted from the allocation, per HCBS Reimbursement rates)

By signing below, I confirm the information provided is accurate and consent to the submission of this request and supporting documentation to the Sedgwick County Developmental Disability Organization (SCDDO) Funding Committee for review.

If I am requesting Self-Directed support and/or to use a licensed childcare provider, I confirm that I understand the SCDDO requires the use an affiliated agency for all staff support and personal care services.

Date

Signature of Individual/Individual's Representative

Printed name of individual/Individual's Representative and if a representative, the relationship to Individual.