DEPARTMENT OF AGING & DISABILITIES
271 W. 3rd St. N., Suite 500, Wichita, KS 67202 • (316) 660-7630 • Fax (316) 660-4911
STEPHEN SHAUGHNESSY, EXECUTIVE DIRECTOR • SEDGWICKCOUNTY.ORG

Family Support Request

$5,000 maximum per fiscal year

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;

Amont 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 07/22/2026

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 (+ 173.39)
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

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 07/22/2026

Household Income

Provide Income information for all members of the household:

Average Monthly Income (Gross)			
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

Average Monthly Expenses			
Mortgage/Rent		Electric/Gas	
Phone/Cable		Water/Trash	
Food/Laundry		Alimony Paid/Child Support	
Transportation (payment, gas, insurance, etc.)		Childcare	
Insurance		Savings	
Retirement		Investments	
Other Payroll Deductions		**Average Monthly Expenses**	$ 0.00
Other (please explain below)		**Average Annual Expenses**	$ 0.00

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

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. Doctors 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
   If requesting camp, the current Individualized — ○ Yes ○ N/A
6. 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.