



For Office Use Only	
FY	_____
Local ID	_____
CARE ID	_____

Bexar Mental Retardation Authority

**In-Home and Family Support
IDENTIFYING INFORMATION**

Section 1.

Recipient's Name: _____ Male: _____ Female: _____
(Person with Disability)

Address: _____ City: _____

State: _____ Texas _____ Zip: _____ County: _____

Recipient's Social Security#: _____ Date of Birth: _____

Diagnosis: Mental Retardation PDD or Autism Under 4 yrs Developmental Delay

Date of Evaluation _____

Recipient's Phone#: _____ Best contact number: _____

Person Completing application: _____

Relationship to individual with disability: _____ Phone: _____

Total Number living in Home: _____ Age of main caregiver _____ Primary Language: _____

IF THE FOLLOWING INFORMATION IS NOT INCLUDED WITH THE SUBMISSION OF THE APPLICATION IT WILL NOT BE PROCESSED IN A TIMELY MANNER AND COULD DELAY SERVICES. (RESIDENCY, DIAGNOSIS, INCOME AND NEED)

Section 2. PROOF OF RESIDENCY, DIAGNOSIS, INCOME

Proof of Residency: *Attach a copy of a document with your current address: (This may be a copy of a current utility bill, rental agreement, statement of landlord, Social Security benefit letter-must be addressed to the applicant and not a payee unless the payee is the parent of a minor child, driver's license-the address on the driver's license must match the address on the applicant's application.)*

Proof of Disability: *Are you currently receiving Service Coordination (General Revenue) services from AACOG Bexar MRA? ___ Yes ___ No If yes, you may request documentation confirming your disability from your Service Coordinator. Who is your Service Coordinator? _____*

If you are NOT a AACOG Bexar MRA client, please include documentation confirming your disability. (If still in school, comprehensive individual assessment from the school or other evaluation information indicating a mental retardation diagnosis and level of functioning is acceptable.)

Proof of Income: *Attach a copy of proof of income. Review the Financial Factor page for a reference of what is needed.*

What is your Adjusted Gross Income: _____

Monthly SSI/or SSDI: _____ MEDICAID NUMBER: _____

*Trust Fund Disbursement: _____
(Source/Monthly Amount)*

*Other Income: _____
(Source/Monthly Amount)*

FINANCIAL FACTOR (40 TAC §1.407(a)(3))

Income is used to determine if an applicant is required to pay a copay (based on median income criteria and provided yearly by DADS). Income is the current adjusted gross income or net earnings of:

- *the person who is age 18 years or older and the person's spouse, if any; or*
- *the biological or adoptive parents of a person who is under age 18 years.*

The income of anyone else is not considered, including the income of:

- *the person's guardian, if any;*
- *the adult person's roommates;*
- *the adult person's parents or other family members;*
- *the person who is younger than 18 years of age (including child support received and Social Security benefits); or*
- *the siblings, extended family members, step parents, or foster parents of the person who is younger than 18 years of age.*

Appropriate income documentation includes the following:

1. *Salary and wages: income tax returns or pay stubs can be used to verify this type of income. Documentation must be the latest available. Pay stub should be within the previous three-month period. Do NOT accept pay stubs that are more than a year old. Income tax returns must be the most current one or a copy of the current request for an extension (with estimated income) for filing the latest return. For persons that are self-employed, a tax return or extension request should show their income.*
2. *Social Security benefits: benefit award letters are sent to individuals receiving these benefits once a year stating what type of Social Security benefits that the individual is receiving and the amount they will receive monthly. Bank statements will also show direct deposits of this income if the individual uses this method of payment from Social Security.*
3. *Other monthly income could include trust fund payments or railroad retirement payments that an individual may receive. Trust funds usually specify what the trust will and will not pay for. Check with the trust fund manager as to what is covered.*

Note: Administering agency's financial assessment documents alone are not sufficient for financial documentation for IHFS.

Note: An applicant that is in arrears in child support payments is not eligible unless the applicant has an agreement and current payment plan on child support in arrears. This is based on self-reports but additional documentation may be requested

No Income: An applicant who does not have any income may provide a document stating such. The document must be signed by the applicant and a witness.

Bexar MRA In-Home and Family Support Alternate Funding List

Below is a list of alternate funding sources that provide the service(s) you have requested. Per the In-Home and Family Support TAC code families must seek alternate funding sources prior to requesting assistance from IHFS. If an individual is eligible for services through another agency then that individual must provide proof that they have requested that service(s) and either been denied or placed on that agency's interest list. If denied services please provide a copy of denial letter, if placed on interest list please complete form below.

1)

Medically Dependent Children Program (MDCP) offers home and community-based services to medically dependent children and young adults (under 21 years of age) as an alternative to a nursing facility. MDCP is designed to provide respite, adjunct support services, adaptive aids, and minor home modifications in support of families caring for their minor children and young adult children with disabilities. A statewide Interest List for MDCP is maintained. Services are provided to a limited number of eligible individuals on a first-come, first-serve basis. For more information, call 1(877) 438-5658.

Contact Person: _____ **Date Contacted:** _____

Outcome: _____

2)

Community Living Assistance and Support Services (CLASS) Program provides home and community-based services to both children and adults with a related condition, which is a disability, other than mental retardation, that originated before age 22 years and that affects the ability to function in daily life. Services include respite, nursing services, adaptive aids and medical supplies, minor home modifications, case management, and other related services, offering a cost-effective alternative to an ICF/MR. CLASS is available only in certain geographic areas in the state. For more information, call 1(877) 438-5658.

Contact Person: _____ **Date Contacted:** _____

Outcome: _____

3)

Community-Based Alternatives (CBA) Program provides home and community-based services to aged and disabled adults (21 years of age or older) as a cost-effective alternative to institutional care in a nursing facility. Services include respite, nursing services, adaptive aids and medical supplies, minor home modifications, home delivered meals, adult foster care, assisted living/residential care services, emergency response services, prescription drugs, case management, and other related services. For more information contact your local DADS CCAD Office 1(877) 438-5658.

Contact Person: _____ **Date Contacted:** _____

Outcome: _____

4)

Deaf-Blind Multiple Disabilities Program serves adults (18 years of age and older) who are deaf and blind and who have another disability that has resulted in a demonstrated need for daily habilitation services. The program is provided statewide as a cost-effective alternative to ICF/MR institutional placement. Services include adaptive aids and medical supplies, assisted living (in settings that serve no more than 6 individuals), behavior communication services, case management, habilitation, minor home modifications, respite, nursing services, prescription drugs, and other related therapies. To apply for services, call 1(877) 438-5658 and ask for the DB-MD waiver program.

Contact Person: _____ **Date Contacted:** _____

Outcome: _____

5)

Department of Assistive and Rehabilitative Services (DARS)

DARS helps individuals prepare for, find, and keep employment. Individuals with a physical or mental disability that results in a substantial impediment to employment are eligible. Vocational rehabilitation services include supported employment, extended rehabilitation services, and transition planning. Call 1(800) 628-5115 or visit the web at: <http://www.dars.state.tx.us/>

DARS also provides support to families with children (from birth to 3 years of age) with disabilities or developmental delays through Early Childhood Intervention (ECI) Services. More information is available by calling 1(800) 250-2246 or by visiting the Web at: <http://www.dars.state.tx.us>
DADS

Contact Person: _____ **Date Contacted:** _____

Outcome: _____

6)

Home and Community-based Services (HCS) Program: The HCS Program provides services to individuals with mental retardation who live with their family, in their own home, in a foster/companion care setting, or in a residence with no more than four individuals who also receive services. The HCS Program provides services to meet an individual's needs so that he/she can maintain him/herself in the community and have opportunities to participate as a citizen to the maximum extent possible. Services consist of case management, adaptive aids, minor home modifications, counseling and therapies, dental treatment, nursing, residential assistance, respite, day habilitation, and supported employment. In the HCS Program, individuals pay for their room and board either with their SSI check or other personal resources. There is a limit to the yearly cost of services provided through the HCS Program. To be placed on the HCS and General Revenue interest list call 210-832-5020 and request to speak to an Intake worker.

Contact Person: _____ **Date Contacted:** _____

Outcome: _____

List any other resources contacted for requested services: _____

Date

Signature of Individual / Family member

Printed Name

Section 3.

Service/Needs Requests

What type of assistance are you requesting? _____

Why is this assistance needed? _____

How can this assistance help the recipient's current situation? _____

If this request is funded, what outcome or goal do you hope to achieve? _____

How much do you estimate the required support will cost? _____

Hours per month: _____ Cost per hour? _____

Who will check be made out to? _____

List names of organizations, contact person, date and result of contact of other resources you have contacted to assist with this need. _____

IHFS DOES NOT PROVIDE PROVIDERS FOR REQUESTED SERVICES. It is the families responsibility to have a provider secured. Failure to include the below information may result in delayed services. All listed information is required at the time the application is submitted.

Provider Information: Name: _____

Address: _____

City, State, Zip _____

Phone Number _____

Social Security Number: _____

Attach a copy of providers Drivers license

Provider Qualifications: (what makes this person qualified to provider the above services to the recipient?)

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City, State, Zip _____

Phone Number _____

Social Security Number: _____

Attach a copy of providers Drivers license

Provider Qualifications: (what makes this person qualified to provider the above services to the recipient?)

Section 4.

In-Home and Family Support is a **program of last resort.** Therefore, all other possible resources must be investigated prior to consideration for IHFS funding. Any goods or services available through an alternate resource will not be funded.

Please Check any of the following programs that the applicant is **currently receiving.**

- Medicare Medicaid Medicaid / Star + Plus Private Insurance QMB only CAS
 Chips MDCP CLASS CBA HCS CWP FC (Family Care)

Other: _____

Please check any of the following programs from which the applicant is awaiting services.

- Medicare Medicaid Private Insurance QMB only CAS CWP
 Chips MDCP CLASS CBA HCS FC (Family Care)

Other: _____

Section 5.

- Do you reside in a Board and Care or Personal Care Facility? ___ Yes ___ No.
Do you reside in a nursing home? ___ Yes ___ No
Do you reside in any other type of residential facility designed to provide 24-hour care and / or treatment? ___ Yes ___ No
Do you live in a transitional or supported living type of residence? ___ Yes ___ No If yes, please explain _____

Do you now or have you ever participated in the In-Home and Family Support Program administered by DADS (The Texas Department of Human Services) which is for individuals with physical disabilities only? ___ Yes ___ No

Section 6.

Please remember to provide the following with your application: (When applicable)

1. **Letters** from a physician or therapist stating the need for such things as
 - a. Special equipment
 - b. PT/OT
 - c. Speech Therapy
 - d. Developmental toys
 - e. Dental
 - f. Psychotropic medication

2. **Bids**
 - a. Verbal-between \$250- \$599, three oral bids are required for any expenditure or architectural modification
 - b. Written-three written bids must be attached for any expenditure or architectural modification costing more than \$599.

Please Note: Any equipment or architectural modification costing over \$600 will use the “One Time only” grant and the recipient will not be eligible for future equipment modification over \$600.

Section 7.

******PLEASE READ THE FOLLOWING IMPORTANT INFORMATION CAREFULLY******

- ❖ In Home and Family Support funds are based on availability. If funds are unavailable applicants may be placed on an Interest List.
 - ❖ If there are any changes in your qualifying factors during the fiscal year (income, residency, diagnosis, etc.) you must notify the IHFS program immediately. Failure to do so could result in your request being denied or services discontinued.
 - ❖ If you feel your rights have been denied, you may contact the Rights Officer at 210-832-5062.
 - ❖ **It is a felony to knowingly make a false statement or representation or to solicit or accept support for which you know you are ineligible.**
 - ❖ Any request denied by the In-Home and Family Support Program may be appealed (a copy of the appeal procedure is attached).
-

I certify that the information presented in and submitted with this application is true and complete to the best of my knowledge. Also, I understand that completion of this form does not ensure receipt of IHFS funds and that funds requested are not approved until the request has been reviewed and a written plan is completed and signed.

Recipient/Family Member Signature

Date

**Mail Completed Application to: Bexar MRA
In Home and Family Support
8700 Tesoro Dr. Suite 700
San Antonio, TX 78217**

- **If you need assistance in completing this application please call (210) 832-5020 and ask for an In Home and Family Support Case Worker.**

In Home and Family Support Provider Waiver

Although the AACOG Bexar MRA IHFS may provide some financial assistance for you to pay a provider, families need to understand that the Internal Revenue Service (IRS) and Texas Workforce Commission (TWC) have guidelines about employment, reporting of wages and unemployment compensation, worker's compensation and taxes.

Payment by AACOG Bexar MRA for any services through In Home and Family Support (IHFS) may include but are not limited to the following:

- Respite Care
- Supervision 13+
- Adult Education
- Independent Living Training
- Personal Assistance Services
- Homemaker Services

As you know, hiring someone to provide a service for you establishes an employment relationship. There are certain Federal and State taxes that apply to employment. As the employer, you should become familiar with certain information including but not limited to FICA (Social Security and Medicare), withholding of Federal Income Tax, the filing of IRS form 1099, FUTA (unemployment Tax and Worker's Compensation), etc. You may wish to contact the following telephone numbers for assistance with meeting these requirements:

IRS Number:	800-829-1040
IRS TDD number:	800-829-4059
Publications Number:	800-829-3676
Texas Workforce Commission Number	800-832-9243

AACOG Bexar MRA is not responsible for checking the background of the provider, the conduct of the provider, injury to family member or the injury to the provider hired by you. I further understand that the provider I choose is not an employee of AACOG Bexar MRA.

I acknowledge by my signature that I take full responsibility in these matters. I release AACOG Bexar MRA from any responsibility from any Federal Income Tax and Unemployment Tax requirement.

Person Receiving Services/Applicant Parent/Guardian

Date

LEARNING YOUR RESPONSIBILITIES AS AN EMPLOYER

ENTÉRESE DE SUS RESPONSABILIDADES COMO EMPLEADOR

If you hire someone to perform a service in your home, including but not limited to personal care attendant, and respite, you are considered that person's employer. This is true whether you pay the person you have hired with money you receive from the *Texas Department of Mental Health and Mental Retardation (TDMHMR) In-Home and Family Support program (IHFS)*, or with other money. As an employer, you will have certain responsibilities and liabilities specified by law. This includes, but is not limited to, payment of federal and state employment taxes and filing the required paperwork with the appropriate agencies. It is your responsibility to learn your legal obligations as an employer and carry them out as the law requires. The department cannot advise you on these matters. These laws and policies are administered by federal agencies and other state agencies, not the department. To receive your current information on your responsibilities as an employer, please contact the agencies listed below using the numbers listed in the Blue Pages of your local telephone directory. If you have access to the Internet, you may also visit the Internet sites maintained by these agencies to get general information.

Si usted contrata a alguien para que le preste un servicio en su casa, como servicio de atención personal o servicio de cuidado de relevo, a usted se le considera el empleador de esa persona. Éste es el caso aunque le pague a la persona con dinero que recibe del *Programa de Servicios de Apoyo en Casa y para la Familia (IHFS)* del *Departamento de Salud y Retraso Mental de Texas (TDMHMR)*, o con dinero de otras fuentes. Como empleador, usted tendrá ciertas obligaciones y responsabilidades especificadas por la ley. Éstas son, entre otras, pagar los impuestos federales y estatales sobre la nómina y presentar los documentos necesarios ante los departamentos correspondientes. Usted tiene la responsabilidad de saber cuáles son sus obligaciones legales como empleador y cumplirlas como lo exige la ley. El departamento no le puede aconsejar sobre estos asuntos. Estas leyes y normas son administradas por departamentos federales y otros departamentos estatales, no por este departamento. Si desea recibir información actualizada sobre sus responsabilidades como empleador, por favor, llame a los departamentos que aparecen a continuación, usando los números de teléfono en las páginas azules de su directorio telefónico local. Si tiene acceso a Internet, también puede visitar los sitios de estos departamentos para obtener información general.

The Internal Revenue Service/Servicios de Impuestos Internos

<http://www.irs.treas.gov>

The Department of Labor/Departamento de Trabajo

<http://www.dol.gov>

The Texas Workforce Commission/Comisión de la Fuerza Laboral de Texas

<http://www.twc.state.tx.us>

In-Home and Family Support Program

APPEAL AND REVIEW PROCESS

APPEAL

If you do not agree with the determination made by an administering agency of the TDMHMR In-Home and Family Support Program you may request an appeal in accordance with the administering agency's procedures.

- (1) The appeal will be conducted by someone who was not involved in making the determination with which you disagree.
- (2) The administering agency will begin conducting the appeal within 10 working days after it receives your request and the appeal will be completed within 10 working days after it begins unless an extension is granted by the chief executive officer of the administering agency.
- (3) The person conducting the appeal will provide you with an opportunity to express your concerns in person or by telephone and:
 - (A) to have your representative talk with the person conducting the appeal; or
 - (B) to submit your concerns in writing, on tape, or in some other fashion.
- (4) The appeal will include a review of:
 - (A) the determination with which you disagree and the rules and policies governing the TDMHMR In-Home and Family Support Program (i.e., Texas Administrative Code, Title 40, Chapter 1, Subchapter I, and the In-Home and Family Support Program Manual); and
 - (B) the information, concerns, and documentation that you express and submit that supports your disagreement.
- (5) The person conducting the appeal will make a decision that will uphold, reverse, or modify the original determination.
- (6) The appeal decision and the reasons for the decision will be explained to you in person or by telephone, if requested. You will also be provided written notification that includes:
 - (A) the appeal decision and the reasons for the decision;
 - (B) a statement that you have the right to have the appeal decision reviewed by the Office of Legal Services at DADS Central Office if you disagree with the appeal decision;
 - (C) a statement that a request for review must be submitted to HHSC Appeals Division, P.O. Box 149030, MC W-613, Austin, TX, 78714-9030, and include:
 - (i) your name, address, and telephone number with area code;
 - (ii) the name of the administering agency; and
 - (iii) a copy of the appeal decision and an explanation of why you disagree with the appeal decision; and
 - (D) a statement that the appeal must be received by the director of legal services within 10 working days after you receive the written notification of the appeal decision.

REVIEW

If you request a review of the appeal decision in accordance with the procedures contained the written notification, then a review will be conducted as described below.

(1) You may choose to have the review conducted:

(A) by telephone conference with you and a representative from the administering agency providing verbal testimony and submitting documentation; or

(B) by desk review with you and a representative from the administering agency submitting documentation.

(2) The review will be conducted no sooner than 10 working days after receipt of the request for review and be completed no later than 30 working days after receipt of the request unless an extension is granted by the director of legal services.

(3) The review will include an examination of:

(A) the appeal decision;

(B) all verbal testimony if the review was conducted by telephone conference;

(C) all documentation submitted by you and the administering agency; and

(D) the rules and policies governing the TDMHMR In-Home and Family Support Program (i.e., Texas Administrative Code, Title 40, Chapter 1, Subchapter I, and the In-Home and Family Support Program Manual).

(4) The reviewer may consult with DADS staff who coordinate the TDMHMR In-Home and Family Support Program and staff who are responsible for the policy contained in the rules governing the program.

(5) The reviewer will make a final decision that will uphold, reverse, or modify the appeal decision.

(6) Within five working days after the review, the reviewer will send written notification of the final decision to you and the administering agency.

(7) The administering agency will take appropriate action consistent with the final decision.

Updated: January 6, 2006