Washington County

Community Services

WCCS-75000-34 (10-18) 2p

ATTACHMENT B

Family Support Grant Application

Name of Applicant:			Birth Date:
Parent Name:			Telephone:
Street Address:	City:	State:	ZIP Code:
Case Manager:			Telephone:
Email Address:			

Disability Eligibility:

Certified Disabled (SMRT or SSA): ☐Yes ☐No List Disability: _____

Please send a copy of verification of disability from social security or the State Medical Review Team with application.

Open with I/DD case management services: ☐Yes ☐No

Type of Grant being requested

☐Monthly ☐ Lump Sum ☐ One Time Support Grant

RESOURCES:

- Check financial resource currently available to the family. (Minnesota Rules part 9540.0400, subpart 3 states that costs which are reimbursable through other sources shall not be reimbursed by the Family Support Grant Program):

Private Insurance: ☐Available ☐Not available
Is the child on Medical Assistance? ☐Yes ☐No

HCBS Waiver/PCA/CSG: ☐Currently receiving: _____ ☐Ineligible ☐ N/A

Residency Eligibility:

Is child currently living in your home? ☐Yes ☐No

Please write a short summary on the how the Family Support Grant would be used to help your child return home and remain in your home. If living out of the home (18 years or older) how will this assist with independent living skills related to vocational services/employment.

Information on Person needing Family Support Grant: (use back for more space if needed)

Medical Needs: ☐ Yes ☐ No

Vision/Hearing/seizures: ☐ Yes ☐ No

Gross Motor Skills: ☐ Yes ☐ No
Ambulatory?
(Wheel chair, assists with transfers, etc.)

Therapy Needs: ☐ Yes ☐ No
(OT, PT, Counseling, etc.)

Sensory Needs: ☐ Yes ☐ No
(Sensory program. Hypersensitive, etc.)

Equipment/Home Mods: ☐ Yes ☐ No

Personal Care Assistance: ☐ Yes ☐ No
(Toileting, eating, dressing, grooming, etc.)

Communication Skills: ☐ Yes ☐ No
(Verbal, can make needs known?)

Supervision needed: ☐ Yes ☐ No
(24 hours, minimal)

Behaviors: ☐ Yes ☐ No

(List all that apply)

Income Requirements:

Families with annual adjusted *gross incomes of $105,230.00 or greater are not eligible* for grant program except in cases where extreme Hardship is demonstrated.

Please complete the hardship application in **addition** to the required forms to still be considered for the Grant – not completing this will cause a delay in processing the application.

In order to establish eligibility status, please indicate your annual adjusted gross income as reported on your most recent 1040 tax form: $ _____ **(Send copy from the most recent 1040 or 1040A that shows the adjusted gross income *and* fill out W-9.** W-9 only needs to be fill out once at initial application.)

Parent Statement of Informed Consent

If authorized to receive a grant, I will assure that:

1. All services and items to be purchased with this support grant will:
    a. Be related to my child's Family Support Grant Plan;
    b. Be over and above the normal costs of caring for my child if my child did not have a disability;
    c. Be directly attributable to my child's disability; and
    d. Enable our family to care for and maintain our child at home or achieve employment success.

2. The items and services to be purchased with the support grant are not reimbursable through other funding sources. (i.e. Medical Assistance, private insurance). I understand denial documentation may be requested from the county to show other funding sources are not covering certain items or services

3. All support grant expenditures will be within the eligible expense categories as defined on Attachment B for the Family Support Grant.

4. Receipts will be turned into the case manager or grant coordinator quarterly and I will save copies of my receipts for at least two years for my own record.

5. I will notify my service coordinator of changes in our family's circumstances which may affect my child's continued grant eligibility.

6. I will not be enrolled on any MA programs unless authorized by coordinator that will make me ineligible while receiving funds and understand that if this happens without approval I will be requested to return the grant funds to the county for that time period.

I certify that all the information in this application regarding my child and our family is true to my knowledge. I have reviewed the Definitions of Reimbursable Expenses and agree to use the grant within the eligible expense categories. I have read items one through five above and certify that all conditions therein be met.

Parent/Person Signature _____ Date _____

APPEALS AND COMPLAINTS

Applicants have the right to appeal the decisions regarding this application. Such concerns may include the denial, suspension or termination of a grant. You may request the assistance of the county agency to file and appeal or you may appeal directly to the Appeals Office of the Minnesota Department of Human Services at the address given below. Your appeal must be in writing and signed by you or your representative. Appeals must be registered with:

Appeals Office

Minnesota Department of Human Services

444 Lafayette Road

St. Paul, MN 55155-3813

Telephone: (651) 296-5764

TDD: (651) 296-7385

Toll Free: 1-800-657-3510

Appeals must be submitted within 30 days of receipt of the results of the application. However, if you have a good reason for not having submitted the appeal within the 30 day limit, you may appeal up to 90 days following receipt. Your grant will be continued at its former amount if you file and appeal prior to the effective date shown. Your grant will be changed during the time before the appeal decision if another unrelated cause occurs; in such an event, you will receive a new notice, which may also be appealed if you are dissatisfied. If you lose the appeal, any overpayment you received between the effective date of this action and the appeal decision will have to be refunded to the county agency. If you are not now receiving a grant and you appeal the denial of a grant to you, you will not be eligible for a grant until you either win the appeal of reapply and are found eligible. You may appeal a denial and reapply at the same time. The appeal hearing will be held at a place convenient to you. You will receive an advance notice by mail of the date, time and place. You may bring a relative, friend or spokesperson with you. You will receive a written decision after the hearing.

Applicants have the right to file a complaint if they believe they have been discriminated against in any way in the handling of their application or grant because of race, color, national origin, religion, sex, age, marital status, political beliefs or because of physical, mental or emotional disability. Complaints related to discrimination may be filed with either of the departments listed below:

Minnesota Department of Human Services

444 Lafayette Road

St. Paul, MN 55155

or

Minnesota Department of Human Rights

190 East 5th Street

St. Paul, MN 55101