Family Support Subsidy Renewal Application

Attached is the reapplication package for the Family Support Subsidy. If you would like assistance completing the application, you may contact a Department of Human Services social worker.

The Family Support Subsidy program consists of a monthly cash payment made to families who have a child with a disability. The subsidy is meant to help keep families together by defraying some of the special costs of caring for a child with a disability at home. The program is based on the assumption that the most desirable place for a child is at home and that the family is the most knowledgeable about what supports are needed and appropriate for their child.

ELIGIBILITY

To qualify for this program:

- Your child must be **less than 18 years of age**.
- Your child must meet the definition of having a **developmental disability**.
- Your child currently **lives in your home** and you are the child's **parent or guardian**, or there is a discharge plan for the child to return home in the next 60 days.
- You **live in Iowa**.
- Your family's **net (not gross) taxable income** for the calendar year immediately proceeding the date of application **did not exceed $40,000**, unless it can be verified that your estimated taxable income for the year in which the application is made will be less than $40,000.
- Families who receive a special needs adoption subsidy are not eligible for the Family Support Subsidy (FSS).
- Children who receive Medicaid waiver services and live in a county that has a Children at Home program are not eligible for FSS. (The counties include Black Hawk, Boone, Cass, Cerro Gordo, Chickasaw, Clinton, Dubuque, Floyd, Grundy, Jackson, Johnson, Keokuk, Mahaska, Mills, Mitchell, Monroe, Montgomery, Story, Wapello, and Washington.)

FILLING OUT THE FORM

1. Identification information: Fill in your child's name and other information.
   Note: If you have more than one child with a disability, you must complete separate applications for each child.
2. Parent or guardian: Fill in your name and other information.

3. Family services plan: This section asks for information on how you think you would use the subsidy payments. You may change your plans during the year as long as the subsidy is used for your child's special needs. If your needs are not listed, feel free to use the "other" category.

4. Taxable income: **A <u>signed</u> copy of your most recent <u>federal</u> income tax return must be attached**. If your income is such that you do not file a federal form, another form of income verification must be attached. If your annual taxable income is over $40,000, you are not eligible unless you can verify that your estimated taxable income for the year in which the application is made will be less than $40,000.

5. Family support survey. Please take a moment to complete a brief survey and to add any additional comments you wish to make about the Family Support Subsidy program.

6. Read this section carefully before signing. Your signature means that you will spend the subsidy on your child for your child's special needs. There are repayment penalties and the possibility of being dropped from the program if these guidelines are not followed.

VERIFICATION OF CHILD'S DISABILITY

When using this form, the doctor or educator completing it needs to be familiar with your child and the definition of developmental disability, which is contained on the form itself. A doctor, nurse, or an education professional may complete this form.

WHAT HAPPENS NEXT

Please complete and return the application and required forms to: Comprehensive Family Support Program, DHS-CFS, 1305 E Walnut, 5th Floor, Des Moines, IA 50319-0114.

If you have any questions, please contact Comprehensive Family Support Program Manager, at 515/281-4522 or 515/281-6248 (FAX).

Iowa Department of Human Services

Family Support Subsidy Renewal Application

1. Identification Information

Child's Name: Last	First	Middle
Date of Birth	Child's Social Security #	
Primary Disability		
Secondary Disability		

2. Parent or Guardian

Name: Last	First	Middle	Social Security #
Address			
City	State	Zip	County
Home Phone	Work Phone		

3. Family Services Plan

Check the items which best describe your family's special needs for which the subsidy might be used:

- ☐ Respite care
- ☐ Recreation
- ☐ Special foods
- ☐ Parent training
- ☐ Transportation
- ☐ Adaptive equipment
- ☐ Insurance
- ☐ Counseling
- ☐ Home modification
- ☐ Other (please list):

4. Taxable Income

Check the box which includes your most recent annual **net taxable income**. **A signed copy of your most recent federal income tax return must be attached**. If your income is such that you do not file a federal form, another form of income verification must be attached.

☐ $ 9,999 and under ☐ $10,000 – $19,999 ☐ $20,000 – $39,999 ☐ Above $40,000 *

***** Not eligible unless verified that your estimated taxable income for the year in which the application is made will be less than $40,000.

5. Family Support Survey (check the response that best matches your experience)

Please answer the following statements.

The Family Support Subsidy…	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
A. Helps me meet my child's special needs.	☐	☐	☐	☐	☐
B. Helps reduce the financial burden of raising a child with a disability.	☐	☐	☐	☐	☐
C. Helps reduce family stress.	☐	☐	☐	☐	☐
D. Overall I find the FSS program helpful.	☐	☐	☐	☐	☐

E. Additional comments. _____

_____

_____

6. Declaration

I declare that this information is true to the best of my knowledge. Any subsidy funds received will be used for the special needs of our child which are not covered by Medicaid. I understand that I am required to report to the DHS local office within ten working days any changes which may affect eligibility. Failure to do so may result in responsibility for repayment of funds and termination of the subsidy. I understand that if I receive benefits through the Family Investment Program (FIP - formerly ADC), the payment I receive from the Family Support Subsidy program shall not be used to cover needs provided for by FIP.

Signature of Applicant	Date

FOR DEPARTMENT USE ONLY

Date **completed** application received in local office: _____

Date sent to Central Office: _____

☐ Eligible ☐ Ineligible ☐ Eligible, pending additional funds

Authorized Signature	Title

Date received in Central Office: _____

Family Support Subsidy Renewal Application Verification

Dear Health Practitioner or Educator:

The Family Support Subsidy program is designed to assist families to defray some of the special costs of caring for a child with disabilities at home. In order to determine eligibility for the Family Support Subsidy program, your help is requested in verifying our child's disability.

Child's Name:
Child's Address:

Signature of Parent

The above-named child has a developmental disability. Persons with developmental disabilities have severe, chronic conditions that:

- Are attributable to a mental or physical impairment or combination of mental and physical impairments;
- Are manifested before the person attains age 22;
- Result in substantial functional limitation in three or more of the following areas of major life activities:
  - Self care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency
- Reflect the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated; except that such term, when applied to infants and young children means individuals from birth to age five, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

I hereby verify that the above-named child has a developmental disability as defined above.

Child's primary diagnosis/disability: _____

Child's secondary diagnosis/disabiliy: _____

Signature of Medical or Educational Professional	Date	License Number (if applicable)