Department of Intellectual & Developmental Disabilities | Family Support Program

2023/2024
FAMILY SUPPORT SERVICE PLAN

THIS PLAN IS VALID THROUGH JUNE 30, 2024

Agency Name	Agency Address	Phone #	Fax #

Name of Person Supported:	Social Security Number:	Date of Birth:
Name of Primary Family Member:	Phone Number:	Email Address:
Client ID# (optional):	Reason for the Need for Support:	

Services To Be Provided ***Please check all which apply**

Before/After Care		Home Modifications		Specialized Equipment & Repair and/or Maintenance	
Behavior Services		Homemaker Services		Specialized Nutrition, Clothing, and/or Supplies	
Day Care		Nursing/Nurse's Aide		Training	
Emergency Living Expenses		Personal Assistance		Transportation	
Family Counseling		Recreation/Summer Camp		Vehicular Modifications	
Health Related		Respite		Other:	
TOTAL Plan Amount not to exceed:				**$**	

Frequency/Duration_____ Method of Payment for Service: _____

**Categories may be changed by recipient as needed as long as the maximum financial commitment is not exceeded. Program participation cannot be guaranteed beyond this contract year. The Family Support Program is funded under an agreement with the State of Tennessee.*

AGREEMENT

The Family Support Program is not responsible for payment of services exceeding the plan allotment. The person who has signed below has participated in the development of this plan and indicates their agreement to the plan by their signature.

The following must be received in the Family Support Office in order to receive services:

1. The signed copy of the Family Support Service Plan and Title VI "Discrimination is Prohibited" Form,
2. Verification of address,
3. Verification of disability and citizenship (if requested).

By signing and dating this form, I, the person supported or legal representative, indicate that all of the information above is true and accurate. Furthermore, I understand providing invalid, inaccurate or incomplete information may result in denial of a claim, disenrollment from the program and/or criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.

_____ _____

Signature of Person Supported or Family | Signature of Agency Representative

_____ _____

Date Signed | Date Signed

☐ Regular Plan ☐ Emergency Plan	Approved by the Local Council	*The Agency complies with Title VI, which prohibits discrimination on the basis of race, color, or nationality.*