TN Disability & Aging

Family Support Program

Madison Haywood Developmental Services, Inc.
P. O. Box 11205
Jackson, TN 38308-0120
731-984-6445 Voice
731-668-2433 Fax

Website Address: www.mhds.org
Email: psykes@mhds.org

Thank you for your interest in the Family Support Program. Below is a description of our program and helpful information.

The Family Support Program is a statewide grant program funded through the Division of Intellectual Disabilities Services. Our program services Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, Madison and McNairy Counties. If you do not reside in one of these counties, please contact us to refer you to the agency that services your county.

The Family Support Program assists individuals who have severe, lifelong disabilities with the cost related to the impact that disability has on the family. Once we receive your application and the required documents (see the second page for a list of these), we will determine whether the applicant is eligible for the program. If the applicant is not eligible, we will send via the mail. If the applicant is eligible, their request will then be placed on a waiting list for their county of residence. Once on the waiting list, the applicant will be contacted annually to update their information.

Each request is reviewed by the Local Council on a quarterly basis. The Local Council consists of multiple representatives from each county and over 50% of the Council is made up of individuals who have disabilities themselves or a representative for an individual with a disability. The Local Council makes the fiscal decisions for the program and set for the guidelines and priorities in which individuals are enrolled into the program. Once you have been approved for services, notifications will be sent via mail.

Our program has limited funds and there is currently a waiting list for each county that we serve. Therefore, it is important your application is completed entirely and that all required documents accompany your application, in a timely manner. If this information is not received, your application will be held as incomplete until all necessary documents are received.

Once again, thank you for your interest in the Family Support Program. We look forward to serving you. If you have any questions, please direct them to the Family Support Coordinator.

Sincerely,

Pam Sykes
Family Support Coordinator

Proudly Serving: Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, Madison and McNairy Counties

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This letter is to inform you that the following documents need to be returned with this application:

1. Proof of Disability: This is a statement completed by a professional listing diagnosis (you MUST include this with your application).

2. Proof of Citizenship: Below is a list of acceptable documents:
   Birth Certificate
   U. S. Passport
   Certificate of Naturalization
   Certificate of Citizenship

3. Proof of Tennessee State Residency: Below is a list of acceptable documents:
   Rent or Mortgage receipt of utility bill
   Tennessee motor vehicle driver's license or identification card issued by the Tennessee Department of Safety
   Tennessee motor vehicle registration
   Employment documents
   Documents showing proof of registering with public or private employment service within Tennessee
   Evidence of enrollment in a school or state
   Evidence of registration to vote in this state

4. An estimate of the cost of the services requested.
   (You MUST include this with the application)

If these documents are not returned, your application is incomplete and cannot be processed.

Sincerely,

Pam Sykes
Family Support Coordinator

TN Department of Disability & Aging

Family Support Program

Madison Haywood Developmental Services

Family Support Intake Form
THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Date: _____ County of Reference: _____

Name of person with a severe/developmental disability that Family Support is applied for:

_____

Social Security #: _____ Date of Birth: ___/___/___

Name of Parent/Spouse/Legal Representative, if different than above: _____

Family's Address: _____ Email: _____

_____ Phone: _____

_____ Phone: _____

Potential Support Services Needed/Requested (check services needed):

- □ Before/After Care
- □ Behavior Services
- □ Day Care
- □ Family Counseling
- □ Emergency Living Expenses
- □ Health Related
- □ Homemaker Services
- □ Home Modifications
- □ Nursing/Nurse's Aide
- □ Personal Assistance
- □ Recreation/Summer Camp
- □ Respite
- □ Vehicle Modifications
- □ Specialized Equipment/Maintenance/Repair
- □ Specialized Nutrition/Clothing/Supplies
- □ Other: _____
- □ Training
- □ Transportation

Do you (the person applying for Family Support) receive any of the following? (Check all that apply)

- □ Adoption Assistance
- □ Food Stamps
- □ Residential Services
- □ Vocational Rehabilitation
- □ Nursing Services
- □ Social Security Income
- □ Social Security Disability
- □ Foster Care
- □ OPTIONS program
- □ None
- □ Tennessee Early Intervention System (TEIS)
- □ PACE (Program of All-Inclusive Care for the Elderly
- □ Supportive Living
- □ MAP's (Medicaid Alternative Pathway to Independence)

What type of insurance do you (the person applying for Family Support) have?

□ TennCare (Medicaid) □ Medicare □ Private Insurance □ Uninsured

Have you (the person applying for Family Support) applied for or do you receive any of the following? (Check all that apply)

□ CHOICES □ ECF CHOICES □ DIDD Waivers □ Katie Beckett Program □ Any in-home or community supports □ None

To comply with Title VI, the following information is requested:

1. RACE (Check all that apply) [federal standards consider "Hispanic/Latino" to be an Ethnicity, to be answered below separate from "Race]:

□ American Indian/Alaskan Native □ African American/Black □ Caucasian/White
□ Hawaiian/Other Pacific Islander □ Asian □ Other

2. ETHNICITY [if self-identified as "Hispanic/Latino," please answer the Race question separately above and then "Hispanic/Latino" here]: □ Hispanic/Latino □ Non-Hispanic/Latino

Family Support Intake Form, page 2

Primary Disability – check which of the following major disability categories is most relevant to the person with a severe disability as a primary diagnosis:

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Deaf
- ☐ Blind
- ☐ Health Impairment
- ☐ Traumatic Brain Injury
- ☐ Other
- ☐ Intellectual Disability
- ☐ Neurological Impairment
- ☐ Orthopedic Impairment/Physical Disability
- ☐ Spinal Cord Injury
- ☐ Developmental Delay
- ☐ Down Syndrome
- ☐ Genetic Disorders (ex. Rett, Angelman, Trisomy 9, etc.)

Please specify _____

Did the person's primary disability occur: ☐ Prior to age 22 ☐ At age 22 or after

Notes: Please explain in detail how the Family Support funds would assist your family. Based on the diagnosis of the applicant, what needs is he/she unable to obtain without these supports? How would the applicant's daily life be improved with this assistance? Use additional paper if necessary.

_____

_____

_____

_____

_____

_____

By signing and dating this Intake Form I, the person applying or their legal representative, indicate that all the information above is true and accurate. Furthermore, I understand that providing invalid, inaccurate, or incomplete information could be considered as fraud and may result in a criminal investigation and disqualification from the program which would prevent re-application in subsequent years.

_____

Signature of Person Applying or Legal Representative Date

How was this information obtained? (i.e. face to face visit, by phone or by mail)

_____

Is someone other than the family/applicant making a referral?

Name of person making the referral to Family Support: _____

Agency: _____ Phone: _____

Address: _____

Family Support Program
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be confidential under Tennessee Code Annotated 33-3-1-5 or protected by federal privacy regulations, Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Service Recipient's Name: _____ Date of Birth _____

Facility providing the information:
(Name/Address

MHDS, Inc. Family Support Program

Person/Organization(s) receiving information:
(Name/Address)

MHDS, Inc. Family Support Program

Specific description of and purpose for the information (including date (s) to be provided:

The client's information regarding disability, previous services through Family Support will be shared with the Family Support program serving the county of residence in hopes of obtaining services FY 2025-2026.

The service recipient or the service recipient's parent/guardian (if a minor), conservator, or legal representative must ready and sign below understanding the following:

- I understand that my health care, eligibility for health care, or the payment for my health care will not be affected if I do not sigh this form.
- I understand that I may see and copy the information described on this form, if I ask for it, and that I get a copy of this form after I sign.
- I understand that this authorization will expire on 06/30/2026 (Day/Month/Year). If no date is specified, this authorization will expire in ninety (90) days from the date of the signature below.
- I understand that I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do, it will have not have effect on the actions taken before I revoked the authorization.
- I understand that the facility has (30) days in which to provide a copy of my records, and if records are stored off premises, sixty (60) days.

By signing and dating this intake 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 Service Recipient, Parent/Guardian, Conservator or Representative Date
(Form must be completed before signing)

Department *of*
DISABILITY & AGING

DISCRIMINATION IS PROHIBITED

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 REQUIRES THAT FEDERALLY ASSISTED PROGRAMS BE FREE OF DISCRIMINATION. THE **TENNESSEE DEPARTMENT OF DISABILITY AND AGING** ALSO REQUIRES THAT ITS ACTIVITIES BE CONDUCTED WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN.

Prohibited Practices Include:

- Denying any individual any services, opportunity, or other benefit for which he or she is otherwise qualified;
- Providing any individual with any service or other benefit, which is different or is provided in a different manner from that which is provided to others under the program;
- Subjecting any individual to segregated or separate treatment in any manner related to his or her receipt of service;
- Restricting any individual in any way in the enjoyment of services; facilities; or any other advantage, privilege, or benefit provided to others under the program;
- Adopting methods of administration that would limit participation by any group of persons supported or subject them to discrimination;
- Addressing an individual in a manner that denotes inferiority because of race, color, or national origin;
- Subjecting any individual to incidents of racial or ethnic harassment, the creation of a hostile racial or ethnic environment, and a disproportionate burden of environmental health risks on minority communities.

Should you feel that you have been discriminated against, please contact the local Title VI Coordinator.

Name: Chad Buckley Title: Director of HR

Address: 57 Conrad Drive Jackson, TN 38305

Phone #: 731-984-6440 Email: cbuckley@mhds.org

Any individual may also file a Title VI complaint with the below listed entities. It is preferable that complaints be registered at the local level first.

DEPARTMENT *of* DISABILITY & AGING
OFFICE OF CIVIL RIGHTS
UBS TOWER, 8TH FLOOR
315 DEADERICK STREET
NASHVILLE, TN 37243
DDA.OCR@tn.gov

or

U.S. DEPARTMENT *of* JUSTICE
CIVIL RIGHTS DIVISION
950 PENNSYLVANIA AVENUE,
N.W. WASHINGTON, D.C. 20530
(855) 856-1247 (toll free voice and TDD)
https://civilrights.justice.gov/report/

		MHDS	
Person Supported	Date	Service Provider	
		Pam Sykes	
Legal Representative	Date	Agency Representative	Date

TN Disability & Aging

Family Support Program

2025-2026 ACKNOWLEDGEMENT OF RECEIPT OF THE APPLEALS GRIEVANCE PROCEDURE AND FRAUD, WAST AND ABUSE POLICY

By signing and dating this form, I, the person support or legal representative, indicate that I have received and understand the forms listed below:

□ Appeals/Grievance Procedure

□ Fraud, Waste and Abuse Policy

_____ _____

Signature of Individual Date Signed

Or

_____ _____

Personal Representative/Guardian as applicable Date Signed

_____ _____

Signature of Agency Employee Date Signed

TN Disability & Aging

Family Support Program

CITIZENSHIP ATTESTATION FORM

Date: _____ Family Support Provider Agency: MHDS, INC.

Name of Family Support Recipient: _____

Address of Family Support Recipient: _____

_____

_____

Phone Number of Family Support Recipient: _____

Please complete the section below and check the appropriate status:

I, _____ (name of Family Support recipient), hereby attest that I am [ ] a United States citizen or [ ] a qualified alien (please check appropriate box). I understand that if I do not provide the appropriate documentation necessary to verify my citizenship or qualified alien status, then I will not be eligible to receive Family Support benefits. Also, I understand that if I knowingly and willfully make a false, fictitious, or fraudulent statement or representation of citizenship or qualified alien status, I may be found to be liable under the False Claims Act in T.C.A. § 4-18-101 et seq., criminal charges under 18 U.S.C. § 911, or any other applicable federal or state statute.

_____

Signature of Family Support Recipient

If form is completed by someone other than the Family Support Recipient:

I, _____, hereby attest that the information provided in this form is true and accurate to the best of my knowledge. Furthermore, I was either given permission by the recipient or have the legal authority to complete and submit this form on his/her behalf.

_____ _____ _____

Relationship to FSP Recipient Signature Date

Note: Return this signed form to your Family Support provider agency
This form must be completed annually.

TN Department of Disability & Aging | Family Support Program

FAMILY SUPPORT PROGRAM
APPEALS/GRIEVANCE PROCEDURE
AND FRAUD, WASTE AND ABUSE POLICY

Appeals/Grievance Procedure

The following procedure shall be followed should a family become dissatisfied or have a dispute pertaining to program operations, staff, services provided, or decisions made. Every effort shall be made to settle the issue as quickly as possible and as close to the source as possible.

The complaint shall first be brought to the attention of the Family Support Coordinator at your local agency. The coordinator will attempt to remedy the situation to the satisfaction of all parties.

If attempts at resolution are unsuccessful at the agency level, the following procedure shall be followed to resolve any complaint or grievance regarding Family Support services:

1. *Local Council Review*-The family shall contact the DDA Regional Office Family Support staff in writing or by phone to report the complaint or grievance. East, TN 423-787-6953, West, TN 901-355-1571, Middle, TN 615-231-5057. This notification shall occur within thirty days of the aggrieved occurrence. The Regional Office will forward the source of complaint or grievance in writing to the Local Council for resolution. The Local Council shall meet with the agency separately from the family, and shall offer to meet with the family separately, to discuss the complaint/grievance and present evidence. The agency is required to have a representative meet with the Local Council. It is the family's choice to either: (1) attend the meeting in person; (2) attend the meeting with an advocate; (3) send an advocate to the meeting on their behalf; or (4) have the Local Council rely solely on the documentation provided by the family. If the family does decide to have an advocate attend the meeting with the Local Council, the family will provide notice to the DDA Regional Office Family Support staff at least 48 hours prior to the meeting. If this deadline is not met, then the meeting will be re-scheduled to a time where the 48-hour timeline for notice by the family can be met. The meeting of the Local Council with the agency may occur at a different date than the meeting of the Local Council with the family or the review of the documentation submitted by the family without their attendance. The meeting(s) of the Local Council shall occur as soon as possible following the receipt of the written complaint/grievance. Within ten business days following both: (1) the meeting of the Local Council with the agency, and (2) either the meeting of the Local Council with the family or a review of the documentation submitted by the family without their attendance; the Local Council shall compile a meeting summary and submit it along with its decision to the DDA Regional Office and Family Support staff as well as notify the family of its decision in writing.
2. *District Council Review* - If the family is not satisfied with the Local Council decision, the family shall contact the DDA Regional Office Family Support staff in writing or by phone within ten business days following receipt of the notification from the Local Council of its decision. East, TN 423-787-6953, West, TN 901-355-1571, Middle, TN 615-231-5057. The Regional Office will forward the complaint or grievance in writing to the District Council for resolution. The District Council shall meet with the agency separately from the family, and shall offer to meet with the family separately, to discuss the complaint/grievance and present evidence. The agency is required to have a representative meet with the District Council. It is the family's choice to either: (1) attend the meeting in person; (2) attend the meeting with an advocate; (3) send an advocate to the meeting on their behalf; or (4) have the District Council rely solely on the documentation provided by the family. If the family does decide to have an advocate attend the meeting

with the District Council, the family will provide notice to the DDA Regional Office Family Support staff at least 48 hours prior to the meeting. If this deadline is not met, then the meeting will be re-scheduled to a time where the 48-hour timeline for notice by the family can be met. The meeting of the District Council with the agency may occur at a different date than the meeting of the District Council with the family or the review of the documentation submitted by the family without their attendance. The meeting(s) of the District Council shall occur as soon as possible following the receipt of the written complaint/grievance. Within ten business days following both: (1) the meeting of the District Council with the agency, and (2) either the meeting of the District Council with the family or the review of the documentation submitted by the family without their attendance; the District Council shall compile a meeting summary and submit it along with its decision to the DDA Regional Office and Family Support staff as well as notify the family of its decision in writing.

3. *State Council Review* - If the family is not satisfied with the District Council decision the family shall contact the DDA Regional Office Family Support staff in writing or by phone within ten business days upon notification from the District Council. East, TN 423-787-6953, West, TN 901-355-1571, Middle, TN 615-231-5057. The Regional Office staff will forward the source of the complaint or grievance in writing to the Chairperson of the Family Support State Council and to the State Coordinator of the Family Support Program. The Family Support State Council will review the complaint or grievance at its next scheduled meeting following the date of the decision of the District Council. While the agency is required to have a representative at the State Council meeting, it is the family's choice to either: (1) attend the meeting in person; (2) attend the meeting with an advocate; (3) send an advocate to the meeting on their behalf; or (4) have the State Council rely solely on the documentation provided by the family. The Regional Office Family Support staff will help the family compile a written form of findings for the Family Support State Council meeting. The State Council shall notify the family of its decision in writing within ten business days following the meeting. The decision of the Family Support State Council is final.

Fraud, Waste and Abuse Policy

The Family Support Program and its staff, provider agencies and volunteers shall comply with DDA Policy 70.2.1 related to preventing, detecting, and reporting fraud, waste and abuse of government funding. Individuals enrolled in the Family Support Program (and/or his/her guardian/conservator) shall comply with DDA Policy 70.2.1, as applicable. See appendix I.

It is expected that the provider agency, volunteers, service providers and the individual enrolled in the Family Support Program (or his/her guardian/conservator) shall cooperate with investigative matters. Failure to cooperate could result in denial of a claim, termination of the Family Support contract, disenrollment from the program and/or a criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.

By signing and dating this form, I, the person supported or legal representative, understand that I must abide by the procedures stated above and as applicable, incorporated in the Family Support Guidelines. Furthermore, I understand that providing invalid, inaccurate, or incomplete information may be considered as fraud, waste or abuse and 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.

*A full copy of the Family Support Guidelines can be located at:

Family Support Guidelines

**Note:* A hard copy may be requested from the agency

*****A signed acknowledgement form must be maintained in the file*****