HOLMES COUNTY
Board of Developmental Disabilities
supporting people in living meaningful lives

Family Support Services Program
Application / 2018-19

Eligible Individual's name______________________________ DOB________________
Eligible Individual lives with ____
Parent/Guardian's name____
Mailing address____
Phone Home__________________________ Cell__________________________
Email Address __________________________________

1. Does Individual currently receive HCBDD Services?

____Yes.

If yes, please identify program

___Early Intervention
___School
___Preschool
___Adult Day Program
___Lynn Hope
___SSA

____No

Were you referred to HCBDD by an agency or individual? If so, please list name(s)

____

____

2. Please check and describe the assistance you receive in caring for your family member with a disability support from groups listed below.

____Private Insurance Co ____
____Bureau of Children w Medical Handicaps_____________________________
____Church ____
____Community Service Organization__________________________________
____Medicaid ____
____Medicaid / Waiver ____
____Social Security ____
____HCAHC ____
____Other (Explain) ____

I certify that the information contained on this application is accurate. I understand that eligibility in the FSS program does not necessarily qualify me or my dependents for other HCBDD Services

______________________________ ______________

Signature Date

Return to FSS Coordinator

FSSDOC1/STH