Family Support Services Request

Name of Individual _____ Date of Request _____

I request Family Support Services reimbursement for the following service which is directly related to improving the living environment or facilitating the care of an individual who has a developmental disability.

_____ Training Type: _____

_____ Counseling Type: _____

_____ Adaptive Equipment Type: _____

_____ Home Modification Type: _____

_____ Special Diet Type: _____

_____ Other Type: _____

TOTAL COST $_____

I acknowledge that all other potential funding sources are **NOT** available i.e., Insurance, Medicaid, Medicare, Easter Seals, HEAP, Public Health Departments or civic organizations for payment of services.

_____ _____
Signature of Parent/Family Member/Guardian Date

_____ Mail check to: _____
Name

_____
Address

_____
Address

_____ Contact me at: _____
Name/Phone

(DO NOT WRITE BELOW THIS LINE)

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_____ APPROVED _____ DISAPPROVED

REASON: _____

_____

_____ _____
SSA DIRECTOR DATE