



**Family Support Services Program
Application / 2026-2027**

Eligible Individual's name _____ DOB _____

Eligible Individual lives with _____

Parent/Guardian's name _____

Mailing address _____

Phone Home _____ Cell _____

Email Address _____

Does Individual currently receive HCBDD Services?

____ Yes. If yes, please identify program/service

____ Early Intervention

____ School

____ Learning Bridge

____ Holmes DD funded Adult Program

____ Holmes DD funded Adult Transportation

____ SSA

____ Other, please list _____

____ No

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

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 Brook Shriver, Office Clerk