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

# Family Support Services Program
# Application / 2022-2023

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 Callie Selders, Office Clerk