

**Tennessee Family Support Program  
@Orange Grove Center  
2026-2027 Application**

The **Tennessee Family Support Program** is a grant program funded through the Tennessee Department of Disability and Aging (DDA). Funding is available for services and supports that are not otherwise covered by insurance or other resources. Please refer to our website for more information about services and supports covered by the Family Support Program.

The program is limited to State of Tennessee residents who have a severe disability {see below} that is life long, permanent and results in significant limitations in their daily life. Funding is available to eligible individuals of *all ages and income levels*.

The primary focus of the Family Support Program is to provide services to those who:

- 1) Were born with a severe or developmental disability or acquired it in childhood
- 2) Have been severely disabled by injury or trauma {brain injury, spinal cord injury, loss of limbs}
- 3) Or have a neurological/neuromuscular disorder {ALS, Muscular Dystrophy, or Multiple Sclerosis}

*Due to limited funding, not all applicants who are eligible may be selected to receive funding.*

Applicants are not guaranteed to be selected for funding from year to year. Selection will be based upon priorities set forth by the District 3 Family Support Council.

Although applications are accepted year-round, open application period is January 1<sup>st</sup> thru April 15<sup>th</sup> of every year. The fiscal year 2026-2027 will begin July 1, 2026 and end June 30, 2027. **Funding will not be available until after July 1, 2026.**

**Please note:**

Individuals who are enrolled in the Katie Beckett Waiver, ECF Choices Program, DIDD Waiver Program, TennCare Choices Program or Pace Program are not eligible to receive Family Support Program Funding. *Mental illness and aging related disabilities are not covered by the Family Support Program.*

**Questions?** *We are here to help!*

Visit: [www.familysupporttn.com](http://www.familysupporttn.com)  
Email: [familysupport@orangegrove.org](mailto:familysupport@orangegrove.org)  
Call: 423-664-5120 (Kristi)

Para ayuda en Español:  
Call: 423-664-5121 Elena  
Email: [msalgado@orangegrove.org](mailto:msalgado@orangegrove.org)

*TN Family Support Program @ Orange Grove Center provides funding for Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea, and Sequatchie Counties*

*Follow us on Facebook! [www.facebook.com/FamilySupportOGC](http://www.facebook.com/FamilySupportOGC)*

## **Application Checklist:**

The following documents are required to apply for the Family Support Program.

*\*Your application cannot be processed until all documents are received by our office.*

*Please submit all documents together!*

- **Intake & Application {attached}**: It is very important that you provide as much information as possible to assist us in determining your eligibility and selection for the program.
- **Proof of Tennessee Residency**: Required annually for all applicants.  
Documents must be dated within the last 60 days.  
Please submit one of the following showing the **date, name, & address** of the applicant:
  - TennCare or other insurance letter/bill
  - Current IEP, IFSP {child applicant's only}
  - SSI or SSDI letter
  - Utility bill (electric, gas, or water)
  - Mortgage or rental agreement

## **New Applicants must also submit the following:**

- **Proof of Severe Disability**: Applicants must submit a statement from their physician that includes their disability and/or diagnosis.
- **Proof of U.S. Citizenship**: The State of Tennessee requires that we have proof of citizenship for all Family Support Applicants. Please submit one of the following: U.S. Birth Certificate, Certificate of Naturalization, or Certificate of Citizenship.

***Please submit all documents together!***

### **Submission options:**

1. Print all documents and mail to:  
Family Support Program  
c/o Orange Grove Center  
615 Derby Street  
Chattanooga, Tn 37404
2. Email all documents (in one email) to:  
fsp@orangegrove.org with applicant name in subject line
3. Fax all documents to 423.664.5122

## Family Support Intake Form

**THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY**

Date: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Name of person supported that Family Support is being applied for: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Name of Legal Representative, if different than above: \_\_\_\_\_

Family's Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

### Potential Support Services Needed/Requested (Check all that apply):

- |                                                    |                                               |                                                                        |                                                                      |
|----------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Before/After Care         | <input type="checkbox"/> Health Related       | <input type="checkbox"/> Recreation/Summer Camp                        | <input type="checkbox"/> Specialized Nutrition/<br>Clothing/Supplies |
| <input type="checkbox"/> Behavior Services         | <input type="checkbox"/> Homemaker Services   | <input type="checkbox"/> Respite                                       | <input type="checkbox"/> Training                                    |
| <input type="checkbox"/> Daycare                   | <input type="checkbox"/> Home Modifications   | <input type="checkbox"/> Service Animals                               | <input type="checkbox"/> Transportation                              |
| <input type="checkbox"/> Emergency Living Expenses | <input type="checkbox"/> Nursing/Nurse's Aide | <input type="checkbox"/> Specialized Equipment &<br>Maintenance/Repair | <input type="checkbox"/> Vehicle Modifications                       |
| <input type="checkbox"/> Family Counseling         | <input type="checkbox"/> Personal Assistance  |                                                                        | <input type="checkbox"/> Other                                       |

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

- |                                               |                                                            |                                                                                      |                                                    |
|-----------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Adoption Assistance  | <input type="checkbox"/> Social Security Income            | <input type="checkbox"/> Tennessee Early Intervention<br>System (TEIS)               | <input type="checkbox"/> Vocational Rehabilitation |
| <input type="checkbox"/> Food Stamps          | <input type="checkbox"/> Social Security Disability Income | <input type="checkbox"/> PACE (Program of All-<br>Inclusive Care for the<br>Elderly) | <input type="checkbox"/> Nursing Services          |
| <input type="checkbox"/> Residential Services | <input type="checkbox"/> Foster Care                       | <input type="checkbox"/> MAPs (Medicaid Alternative<br>Pathway to Independence)      | <input type="checkbox"/> Supported Living          |
| <input type="checkbox"/> OPTIONS Program      |                                                            |                                                                                      | <input type="checkbox"/> None                      |

### 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 ☐ DDA Waivers ☐ Katie Beckett Program ☐ Any in home or community supports  
☐ None

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

- 1 RACE (Check all that apply)** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino  
☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other (including 2 or more races)

## Family Support Intake Form, page 2

**Primary Disability** – Check which of the following “major disability categories” is most relevant to the person services are being requested for (as a primary diagnosis):

- |                                                 |                                                                                                       |
|-------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Autism                 | <input type="checkbox"/> Intellectual Disability                                                      |
| <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Neurological Impairment                                                      |
| <input type="checkbox"/> Blind                  | <input type="checkbox"/> Orthopedic Impairment/ Physical Disability                                   |
| <input type="checkbox"/> Deaf                   | <input type="checkbox"/> Spinal Cord Injury                                                           |
| <input type="checkbox"/> Health Impairment      | <input type="checkbox"/> Developmental Delay (Birth - 5 y.o.)                                         |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Down syndrome                                                                |
| <input type="checkbox"/> Other _____            | <input type="checkbox"/> 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 this support? How would the applicant’s daily life be improved with this assistance? Use additional paper if necessary.

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**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 Supported or Legal Representative**

\_\_\_\_\_  
**Date**

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

**If someone other than the family/applicant is making a referral:**

Name of person making referral to Family Support: \_\_\_\_\_

Agency:\_\_\_\_\_ Phone:\_\_\_\_\_

Address: \_\_\_\_\_

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Has the applicant previously received Family Support Program funding? **YES** **NO**

Does the applicant have a diagnosis of intellectual disability (diagnosed prior to age 18)? **YES** **NO**

Has the applicant applied for or plan to apply for the TennCare ECF Choices Program? **YES** **NO**

Has the applicant applied for or plan to apply for the Katie Beckett Waiver? **YES** **NO**

Please describe the nature of the disability including diagnosis and severity:

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Please describe how the applicant's disability affects their daily life:

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Please list All services (respite, personal assistance, nursing, day programs, etc...) provide by other agencies. Please indicate who is paying for each service (insurance, grant program, scholarship, private pay, etc.)

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Please describe the applicant's current living situation:

(Who does the applicant live with? Who provides care for the applicant?)

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How many people live in the home?\_\_\_\_\_ How many are under 18 years old? \_\_\_\_\_

Is the primary caregiver 75 years old or older? **YES** **NO**

Are there other individuals with disabilities residing in the home? **YES** **NO**

If **YES**, please describe relationship to the applicant and nature of disability:

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### 1. Applicant's Self Care & Daily Living Skills:

| Check appropriate skill level for each daily living skill | Independent | Needs some assistance | Needs full assistance |
|-----------------------------------------------------------|-------------|-----------------------|-----------------------|
| Eating                                                    |             |                       |                       |
| Dressing                                                  |             |                       |                       |
| Bathing                                                   |             |                       |                       |
| Toileting                                                 |             |                       |                       |
| Transfers in/out of bed or wheelchair                     |             |                       |                       |
| Preparing Meals                                           |             |                       |                       |
| Making medical appointments                               |             |                       |                       |
| Shopping for groceries, medications                       |             |                       |                       |
| Completing household tasks/cleaning                       |             |                       |                       |
| Managing money                                            |             |                       |                       |

### 2. Applicant's ability to Communicate:

Is the applicant's ability to communicate affected by their disability? YES NO ☐

If yes, how does the applicant communicate with others? \_\_\_\_\_

Does the applicant have difficulty understanding verbal instructions? YES NO

### 3. Applicant's ability to learn:

Is the applicant's ability to learn affected by their disability? YES ☐ NO ☐

If yes, please describe how learning is affected: \_\_\_\_\_

Is the applicant receiving/have received special education services? YES ☐ NO ☐

### 4. Applicant's Mobility (ability to walk/ move around their home/community):

Is the applicant's mobility (walking) affected by their disability? YES ☐ NO ☐

If yes, how is mobility affected? \_\_\_\_\_

Does the applicant require a wheelchair or other supportive device? YES ☐ NO ☐

If yes, please describe supports needed: \_\_\_\_\_

### 5. Applicant's Self Direction:

Does the applicant need constant supervision due to safety concerns? YES ☐ NO ☐

Is the applicant aware of danger? YES ☐ NO ☐

How does the applicant's disability affect their judgment and ability to make decisions? \_\_\_\_\_

### 6. Economic (adult applicants only)

How does disability affect the applicant's ability to work? \_\_\_\_\_

**Please note that you are applying for funding that will not be available until after July 1, 2026.**  
*Any services that occur prior to July 1, 2026, cannot be requested with this application.*

**What is funding being requested for?** Please describe in detail and include amount of funding needed/requested. Please include estimates for all items, if applicable. If multiple items are requested, please list in order of priority and include the cost of each item.

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*\*The Family Support Program does not provide funding for purchases made prior to request and approval of funding.* **Total Funding Requested: \$\_\_\_\_\_**

Are you receiving funding/assistance from any other source (TennCare, Medicare, private insurance, scholarships, grants, etc...) to help pay for the service you are requesting? **YES** **NO**

**If YES, answer all of the following:**

Who is providing funding? \_\_\_\_\_

How much funding is being received? \_\_\_\_\_

Why is funding also needed by the Family Support Program?

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**By signing this application, you agree that all of the information provided is accurate to the best of your knowledge. Any attempt to provide false or misleading information will result in immediate termination of funding from the Family Support Program.**

\_\_\_\_\_  
Signature of person completing application      Relationship to applicant      Date