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

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 1st thru April 15th 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
Email: familysupport@orangegrove.org
Call: 423-664-5120 (Kristi)

Para ayuda en Español:
Call: 423-664-5121 Elena
Email: 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*

# 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

TN Department of Disability & Aging | Family Support Program

# 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):**

☐Before/After Care
☐Behavior Services
☐Daycare
☐Emergency Living Expenses
☐Family Counseling
☐Health Related
☐Homemaker Services
☐Home Modifications
☐Nursing/Nurse's Aide
☐Personal Assistance
☐Recreation/Summer Camp
☐Respite
☐Service Animals
☐Specialized Equipment & Maintenance/Repair
☐ Specialized Nutrition/ Clothing/Supplies
☐Training
☐Transportation
☐Vehicle Modifications
☐Other

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

☐Adoption Assistance
☐Food Stamps
☐Residential Services
☐Social Security Income
☐Social Security Disability Income
☐Foster Care
☐OPTIONS Program
☐Tennessee Early Intervention System (TEIS)
☐PACE (Program of All-Inclusive Care for the Elderly)
☐MAPs (Medicaid Alternative Pathway to Independence)
☐Vocational Rehabilitation
☐Nursing Services
☐Supported Living
☐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):

- ☐Autism
- ☐Cerebral Palsy
- ☐Blind
- ☐Deaf
- ☐Health Impairment
- ☐Traumatic Brain Injury
- ☐Other _____
- ☐Intellectual Disability
- ☐Neurological Impairment
- ☐Orthopedic Impairment/ Physical Disability
- ☐Spinal Cord Injury
- ☐Developmental Delay (Birth - 8 y.o.)
- ☐Down syndrome
- ☐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.**

_____

_____

_____

_____

_____

_____

**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 <u>including</u> diagnosis and severity:

_____

_____

_____

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

_____

_____

_____

Please list <u>All</u> 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.)

_____

_____

_____

Please describe the applicant's current living situation:
(Who does the applicant live with? Who provides care for the applicant?)

_____

_____

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:

_____

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.

_____

_____

_____

_____

_____

_____

**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?

_____

_____

_____

_____

**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