# First In Families of the Southern Piedmont

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First In Families is an exciting approach to supporting people with developmental disabilities and their families.

Mission:

First In Families of the Southern Piedmont mission is to provide persons with developmental disabilities and/or their families the opportunity to request assistance when needed and to empower them with the knowledge and confidence to pursue their own life choices.

# Developmental Disability

One of the three eligibility requirements to be considered for assistance from First in Families of the Southern Piedmont is that the individual or a family member living in the home has a developmental disability. The following is intended to explain this requirement.

Question: **WHAT IS A DEVELOPMENTAL DISABILITY??**

Response: "Developmental disability" is a severe, chronic disability of a person that:

A. Is attributed to a mental or physical impairment or a combination of mental or physical impairments;
B. Is manifested before the person reaches age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
C. Is likely to continue indefinitely;
D. Results in substantial functional limitations in three or more of the following areas of major life activity:
    - self-care
    - receptive and expressive language
    - capacity for independent living
    - learning
    - mobility
    - self-direction
    - economic self-sufficiency

E. Reflects the person's need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated

**OR**

F. When applied to children from birth to 4 years of age, may be evidenced as a developmental delay.

(Examples of a developmental disability: mental retardation, autism, cerebral palsy, down syndrome, traumatic brain injury.)

**First In Families of the Southern Piedmont**
**c/o The Arc of Union County**
**1653-C Campus Park Drive**
**Monroe, NC 28112**

Cindy Carroll, Chapter Director
(704) 261-1550 ext 204 or 261-1554 (fax)

| *Office use only*: |
|---|
| Date rec'd _____ |
| App. # _____ |
| Met Date _____ |

# First In Families Grant Application

Name of family member with disability:_____

Address:_____ City_____ Zip_____

*Residence Type*: □ At Home □ Group Home □ Independently □ With Friends □ AFL □ Other _____

County_____ Phone (H)_____(Other)_____

Email_____

Date of birth:_____ Race (Opt.):_____Sex □ Male □ Female

***(Asked to ensure we are reaching all ethnic groups in our area)***

What is this person's developmental disability/diagnosis? _____

**How may FIF verify this diagnosis**?_____

Parent/Guardian name:_____ Spouse:_____

Other Contact/Case Manager_____ Phone: _____

How many people live in the home? _____

What is the family's net income (**after taxes**) ?_____ □ Per year □ Per month

***please attach proof of income to this application***

Does anyone else in the home have a disability? □ yes □ no

| Disability: | Name of Person: |
|---|---|
| _____ | _____ |
| _____ | _____ |

The following services may be available in the community. Please check if you are receiving, on a waiting list, or have been denied any of the following:

*If you would like to find out more about the below services or obtain a referral, please ask the FIF Staff or mention this in your request.*

| No/Receive/Wait/Denied | | | | No/Receive/Wait/Denied | | | |
|---|---|---|---|---|---|---|---|
| □ | □ | □ | □ CAP/Innovations | □ | □ | □ | □ Respite Care |
| □ | □ | □ | □ AFDC/TANF | □ | □ | □ | □ In Home nursing |
| □ | □ | □ | □ WIC | □ | □ | □ | □ Supported Employment |
| □ | □ | □ | □ SSDI | □ | □ | □ | □ Behavioral Mang. |
| □ | □ | □ | □ Medicare | □ | □ | □ | □ Developmental preschool |
| □ | □ | □ | □ Medicaid | □ | □ | □ | □ Before/after school care |
| □ | □ | □ | □ SSI/Social Security | □ | □ | □ | □ Early Intervention |
| □ | □ | □ | □ Vocational | □ | □ | □ | □ Case Management |
| □ | □ | □ | □ Speech therapy | □ | □ | □ | □ Counseling |
| □ | □ | □ | □ Physical therapy | □ | □ | □ | □ other_____ |
| □ | □ | □ | □ Occupational therapy | | | | |
| □ | □ | □ | □ Residential | | | | |

Have you received help from FIF before? □ no □ yes (first-time applicants take priority)
If "yes," under whose name?_____
How did you hear about FIF?_____

Please answer the following questions, attaching extra sheets if you would like:
What is your need? _____
_____
What is your dream ?_____
_____
Please describe **in detail** your request and be as specific as possible: _____
_____
_____

FIF hopes to build a network of resources for families like yours. If you have talents, gifts or items you'd like to share with other families in need, please identify them below. (ie, truck or trailer we could borrow to help move furniture; would like to become part of the management team; able to donate space to us; etc.)

_____
_____

By my signature below, I verify that the above information is accurate; I also give my consent for this information to be shared with members of FIF Management Team. My signature on this application also indicates that I understand that I may receive a survey from First In Families of North Carolina asking me to give feedback on the FIF program. I understand that if I choose to complete the survey, those survey results may be shared (anonymously) with others.

_____ _____
Signature of responsible person Date

# Use and Disclosure Authorization

First In Families of the Southern Piedmont
1653-C Campus Park Drive, Monroe, NC 28112
(704) 261-1550

Name of individual with disability: _____

Date of birth: _____

I, _____, (individual or legally responsible person), authorize First In Families of the Southern Piedmont/The Arc of Union County to use or disclose to:

> Piedmont Behavioral Healthcare (PBH), the State of North Carolina Health and Human Services of MH/DD/SA, First In Families of North Carolina, North Carolina Department of Social Services, County Health Department, Children's Developmental Services Agency (CDSA), North Carolina Public Schools, and The Arc of North Carolina's affiliated chapters

the following protected information:

First In Families application information and First In Families funding approval information, which includes name of individual, diagnosis of developmental disability, and funding/assistance requested and/or received from First In Families of the Southern Piedmont.

The purpose of the use and disclosure is to verify eligibility for First In Families to serve the individual/family, to connect individual/family to requested assistance/resources, and to complete required reporting of First In Families resource funding and assistance of individuals/families to managing agencies.

I understand that this authorization expires automatically one year from the date that it is signed unless I request otherwise.

I certify that this authorization is made freely, voluntarily, and without any undue force.

Signature: _____

Date: _____

*Please explain representative's authority to act on behalf of individual: _____