TEXAS
Health and Human Services
Children with Special Health Care Needs Services

CHILDREN WITH SPECIAL HEALTH CARE NEEDS SERVICES PROGRAM

Family Support Services Request

Cover Sheet | FSS Packet Form A

Client Name: _____ **Client ID:** _____

Client Date of Birth: _____

Parent/Guardian Name: _____ **Phone:** _____

Full Street Address:
Include city, state, and zip code. _____

Optional. **Email:** _____

Parent/Guardian or Adult Client Signature:

X_____
Original signature required.

FSS Request Date: _____

ALL REQUESTS

The following forms and documentation are required for all FSS requests:

- ☐ Current Family Needs Assessment (CPW-02 or Family Needs Assessment and Service Plan) is attached.
- ☐ FSS Packet Form B (FSS Request Form) signed by the parent/guardian is attached.
- ☐ For a biddable service or piece of equipment, e.g. home or vehicle modifications, two comparable, itemized bids are attached. If only one bid was obtained, information is included as to why it was not possible to obtain 2 bids.
- ☐ Additional information supporting the FSS Request is attached and/or documented on this form. (As needed)

CAREGIVER/RESPITE PROVIDER TRAINING REQUESTS

The following required information is included or attached:

- ☐ The date(s) and location of training, the name and credentials of trainer(s), copy of agenda if available, training goals and anticipated outcomes(s)
- ☐ Total estimated cost to include transportation, lodging, and registration fees, name of person requesting training and relationship to the client, and a brief description of how the training will benefit the client and assist in maintaining the client in their home.
- ☐ A copy of the training brochure may be submitted if it identifies the first four requirements along with the other information specific to the client.

CHILD CARE SUPPORTS

The following required information is included or attached:

- ☐ Identification of care that is routinely provided by staff at the child care center for all children
- ☐ Identification of the exceptional care needed by the child that must be provided by additional staff or outside licensed nurse, including the frequency, duration, and cost of the exceptional care
- ☐ Requests for coverage of consultation and/or training of child care staff include: Identification of persons providing consultation and/or training and their qualifications, identification of staff being trained, a written description of the training plan, anticipated outcomes along with outcome measures, and cost of consultation or training

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HOME MODIFICATIONS REQUESTS

The following required information is included or attached:

- ☐ FSS Packet Form D (Written Specifications and Approvals for Home Modifications Form) is attached.
- ☐ The attached bids are itemized and/or provide details for the proposed home modifications, including photos/drawings, as appropriate. If the bids include the purchase of equipment, the bids detail the manufacturer and model. If only 1 bid was obtained, information is included as to why it was not possible to obtain 2 bids.
- ☐ If an Initial Home Inspection Form H has been completed attach the report. (An Initial Inspection must be pre-approved by Central Office if done prior to the authorization of the FSS request.)

Select one: Inspection fees should be reimbursed through:

- ◯ Annual benefit
- ◯ Home modification benefit

Lifetime Benefit *(Note: total cost of home modifications where annual benefit is combined with the one-time lifetime home modification benefit cannot exceed $7200.00, including fees for the initial and final inspections.)*

RESPITE REQUESTS

The following is required:

- ☐ The number of respite hours per month, the hourly rate, and the estimated cost. The total amount requested must be based on the number of months remaining in the calendar year. If known, information on the respite provider should be included.

SHORT TERM EMERGENCY UTILITY ASSISTANCE REQUESTS

The following required information is included or attached:

- ☐ For requests for assistance with utility bills, a written statement that the family is able to cover the monthly cost of utility bills following the one to two months of program coverage.
- ☐ For requests for phone installation, a written statement from the client's physician documenting the health justification for the request and a written statement that the family is able to cover the monthly cost of the phone.

SPECIALIZED EQUIPMENT AND SUPPLIES REQUEST

The following required information is included or attached:

- ☐ The attached itemized bids include the equipment manufacturer and model. If only 1 bid was obtained, information is included as to why it was not possible to obtain 2 bids.
- ☐ For requests for air purification systems, air conditioners, and/or heaters in the home or vehicle, a written statement from the client's physician documenting the health justification for the request and a written statement that the family is able to cover the monthly electric bills and routine maintenance.

VEHICLE MODIFICATIONS REQUESTS

- ☐ FSS Packet Form C (Vehicle Evaluation Form) is attached for any vehicle more than 3 years old. If the vehicle is 10 years old or older or has 100,000 miles or more on the odometer, the Vehicle Evaluation Form (FSS Packet Form C) must include a statement from a mechanic that justifies the expense for the purchase and installation of the equipment on an older/high mileage vehicle.
- ☐ For clients 16 years of age or older, FSS packet Summary includes information regarding whether client is eligible for assistance with vehicle modifications through the Department of Assistive and Rehabilitative.
- ☐ For a vehicle owned by someone other than the parent/guardian, written permission for the vehicle modifications from the vehicle's owner is attached.
- ☐ The following information is included in the bids or on the Vehicle Modification Specifications checklist: 1) Vehicle year, make, and model 2) Equipment manufacturer and model 3) Statement that the modification or equipment is anticipated to meet the client's needs for the next four or five years 4) Statement that the modification meets National Highway Traffic Safety Administration requirements. 5) Specifications of the lift
- ☐ For Wheelchair Lifts, bids or the checklist must also detail: 1) Specifications of the wheelchair that will be used with the lift 2) Statement that the lift will accommodate the wheelchair 3) Information on tie downs/occupant restraints OR a written statement from the child's physician or therapist which states that occupant restraints are not necessary is attached.
- ☐ If only one bid was obtained, information is included as to why it was not possible to obtain 2 bids.

REQUESTED FFS | Respite, Child Care Supports, Caregiver/Respite Training

Complete the section(s) related to the requested FSS service(s).

- ☐ Respite
- ☐ Child Care Supports
- ☐ Caregiver/Respite Training

Provider Name:

CSHCN Provider Number:

Full Address:
Include street, city, state, and zip code.

Provider Phone Number:

Provider Fax Number:

Projected Dates/Period of FSS Service (Include projected begin and end date if applicable).
Respite will be prorated for the date of approval through the end of the calendar year based on the requested frequency and cost specified below.

Hours per month requested:

Total number of hours requested:

Hourly pay rate:

Total cost:

Comments/Details. (If necessary attached separate paper.)

REQUESTED FFS | Modifications, Equipment/Supplies, Assistance

Complete the section(s) related to the requested FSS service(s).

- ☐ Home Modification
- ☐ Short Term Emergency Utility Assistance
- ☐ Specialized Equipment/Supplies
- ☐ Vehicle Modification

Provider Name:

CSHCN Provider Number:

Full Address:
Include street, city, state, and zip code.

Provider Phone Number:

Provider Fax Number:

Projected Dates/Period of FSS Service: (Include projected begin and end date if applicable.)

Modification, specialized equipment or supplies, or short term emergency utility assistance requested (Include model, brand, etc for equipment and supplies):

Itemized cost(s): **Total cost:**

Comments/Details: (If necessary attached separate paper.)

Justification. Check applicable box and enter details/information below.
REMINDER: According to policy, when the CSHCN Services Program has a waiting list, the program can only pay for FSS that helps prevent an out-of-home placement OR that is cost effective for the CSHCN Services Program.

☐ Prevent Out-of-Home Placement (Include rationale for risk of out-of-home placement, available supports and other resources explored, status of plans for out-of-home placement, description of how requested service will help to prevent out-of-home placement.)

☐ Cost effectiveness for the CSHCN Services Program (Include rationale for cost effectiveness and cost estimate if known, available supports and other resources explored. The Central Office FSS Coordinator will request specific information on prior expenditures or typical expenditures associated with the child's condition from Central Office staff on receipt of the FSS Request Packet from the Regional Social Work Director.)

☐ Prevent out-of-home placement AND Cost Effectiveness

FSS Packet Summary. Details/Justification Information. (Include information on available supports and other resources explored.)

Total Dollar Amount Requested: **Date:**

Regional Social Work Director Signature

X_____
Original signature required.