



**Family Support Services Request  
 FSS Packet Form B**

**My child and family/ I request the following family support service(s):**

- |                                |  |
|--------------------------------|--|
| Respite                        | Van lift or other vehicle modification |
| Home modification              | Child care assistance                  |
| Specialized equipment/supplies | Short term utility assistance          |
| Other:                         |  |

**I understand that:**

- The Children with Special Health Needs (CSHCN) Services Program may not always have funds to provide my request.
- When funds are limited, my request may be approved only when:
  - There are no other funds that can pay for this item or service;
  - It helps my child to continue to be able to live at home and not in a nursing home or group home;   OR
  - Providing the item or service will lower costs for the CSHCN Services Program.
- In most cases, the annual benefit for family support services for each client cannot be more than \$3,600.00 in a calendar year. Exceptions may be made for vehicle modifications (up to \$7,200.00).
- I understand that the maximum lifetime amount that CSHCN Services Program may provide for home modifications is \$3,600.00 per client, regardless if the child changes residences, etc. I may choose to combine my annual benefit and my lifetime home modification benefit one time for home modifications (up to \$7,200.00).
- I can appeal if the CSHCN Services Program denies all or any part of my request.

**I will:**

- Provide written bids for requested home or vehicle modification work or equipment (2 bids if possible).

**If the CSHCN Services Program approves all or part of my request, I understand that:**

- If requesting respite, I am responsible for selecting, training, directing, and monitoring a person providing respite. I have received the Respite – *Learning Your Responsibilities Fact Sheet* and I understand these responsibilities. I also understand that respite will not be covered if my child's eligibility for the CSHCN Services Program ends.
- If a service or item I requested costs more than the amount CSHCN Services Program approves, I will be responsible for the difference and will need to make arrangements with the provider for payment.
- Payment for an approved service or item will be made after it is completed or delivered and I will not receive a cash advance.
- If required, I must provide an original receipt marked "Paid" for an approved service or item purchased with CSHCN Services Program funds. The receipt must include:
  - The date the specific service or item was purchased, and;
  - The name and other information for the vendor.
- I must return funds to CSHCN Services Program if an approved service or item purchased by the Program is reimbursed by someone else (such as Medicare, private insurance).

**Printed Name:**

Parent/Guardian or Adult Client

**Address:**

Include full street address,  
city, state, and zip code.

**Phone Number:**

(Optional) **Email:**

**Parent/Guardian or Adult Client Signature:**

**Date:**

X \_\_\_\_\_

*Original signature required.*