ARLINGTON VIRGINIA
Human Services

Department of Human Services
Developmental Services
2100 Washington Boulevard, Fourth Floor, Arlington, VA 22204
Tel: 703-228-1700
Fax: 703-228-1148
TTY: 703-228-1788
www.arlingtonva.us/developmental-services

Arlington Department of Human Services
Aging and Disability Services Division
Clinical and Developmental Services Bureau | Developmental Services

Family Support Program Application

Date of application: _____

Name of applicant (family member): _____
Name of individual to receive services: _____

Applicant's address: _____
Telephone: _____
Applicant's relationship to individual to receive services:
_____

Diagnosis:

- ☐ Intellectual Disability
- ☐ Developmental Disability
- ☐ Developmental Delay (for children age 6 and under)
- ☐ Child currently receiving Part C services

I (we) qualify for the Family Support Program because: (Check any that apply.)

- ☐ My (our) annual household taxable income is $107,500 or less. (This is Arlington's median household income. Proof of income, a current Financial Assessment Form, and a W-9 form are required.)
  (Income verified as per _____ by _____ on _____.)
- ☐ I (we) have a disability-related need that cannot be addressed through other funding sources.
- ☐ I (we) have an extraordinary expense need related to caring for a member of the family who has a disability, and lives in my (our) home.

Individual with disability has:

- ☐ Medicaid
- ☐ Medicare
- ☐ Private health insurance

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- ☐ Supplemental Security Income (SSI) $ _____
- ☐ Social Security Disability Insurance (SSDI or SSDI-DAC) $ _____
- ☐ Disabled Adult Child Annuity (Civil Service, Military, Railroad, Other) $ _____
- ☐ Wages $ _____

Families are encouraged to use SSI, SSDI-DAC, and other resources, if available, for regular disability-related expenses. Family support funds are limited, and are intended to assist needy families with extraordinary disability-related expenses.

Disability-related expenses: (please specify)

_____	$_____
_____	$ _____
_____	$ _____

Please check all other public services that the individual currently receives:

- ☐ Support/Service Coordination (Name of Support/Service Coordinator: _____)
- ☐ Residential services
- ☐ Day support or supported employment services
- ☐ County-subsidized van or taxi transportation to day support or worksite
- ☐ Parent – Infant Education Program (PIE)
- ☐ Behavior Intervention Services (BIS)
- ☐ Mental Health Services
- ☐ Arlington County Public Schools (Name of School: _____)
- ☐ Virginia Department of Rehabilitative Services
- ☐ Housing Assistance
- ☐ Section 8
- ☐ Other type of service or subsidy: _____

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I understand that I am applying for reimbursement of extraordinary disability-related expenses on behalf of a family member with a disability living in my home. The information given is accurate to the best of my knowledge. I agree to notify the IDD Support/Service Coordinator if my income increases, the individual with the disability moves out of my home, or if our address changes. I understand that reimbursement income received may be reported by Arlington County to the Internal Revenue Service under my name and Social Security Number, as required by federal regulation.

_____ _____
Applicant/Parent/Caregiver Signature Date

_____ _____
Staff Signature Date