LifeQuest

Creating opportunities that enrich lives

APPLICATION FOR FAMILY SUPPORT

(Please print or type)

PARENT/GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE:_____

ZIP CODE: _____ COUNTY: _____ PHONE (best number) _____

EMAIL: _____

NAME OF INDIVIDUAL(S) WITH DEVELOPMENTAL DISABILITY	DIAGNOSIS	DOB	SSN	MEDICAID Y/N	IEP/IFSP Y/N	RACE	SEX

Documentation of the individual's diagnosis and functional limitations, such as Birth-to-3 evaluations, psychological-educational testing scores, or other evaluations pertinent to the individual's diagnosis should be submitted. If questions should arise regarding documentation, please call the number listed below.

Relationship to the individual with special needs: _____

Does the individual reside in your home? YES NO

What is your funding request? (optional) _____
_____

What is the estimated cost? (optional) _____
_____

Briefly describe how this funding will assist in meeting the needs of the individual: _____
_____
_____
_____

I understand that for an individual to be eligible for Family Support services, he/she must have a diagnosed developmental or intellectual disability. I hereby attest that individual named on this form meets the eligibility requirements for the Family Support Program.

SIGNATURE:_____ DATE:_____

RETURN TO: Family Support c/o Jessica Lang
804 N. Mentzer
Mitchell, SD 57301
605-990-7813