Shawano County Department of Community Programs

Family Support Program

Application – 2009

Application Date: _____ Child's Name: _____

Gender: M or F Child's Date of Birth: _____ Current Age: _____

Child's Social Security Number: _____-_____-_____

Parent/Guardian: _____ Address: _____

City: _____ Zip Code: _____ Telephone Number: _____

Best Time to Contact: _____

Optional Information:

Family Structure: ___ Married ___ Single ___ Widowed ___ Divorced ___ Other

Number of Children in the home: _____

Description of the Child

Child's disability, if diagnosed by medical personnel (check all appropriate responses)

☐ Autism ☐ Blind ☐ Deaf ☐ Epilepsy ☐ Dyslexia ☐ Cerebral Palsy

☐ Cognitive Disability ☐ Emotionally Disturbed ☐ Muscular Dystrophy

☐ Neurological Impairment ☐ Physical Impairment ☐ Other _____

Description of Current Services to Child and Family:

MA Number: _____ Katie Becket: ☐ Yes ☐ No

SSI: ☐ Yes ☐ No W2: ☐ Yes ☐ No WIC: ☐ Yes ☐ No

Other Benefit Programs: _____

Family Health Insurance: (Company Name and type)

_____

_____

The Family Support Program was created *to enable parents of children with disabilities to care for their children in their own homes rather than placing them in institutions or other out of home placements, thereby enhancing the quality of life; to improve the availability and coordination of community services to families; and to increase the control of families over the types of services and goods provided to them.* s.46.985(2), Wisconsin statutes.

Answering the following questions with the program purpose in mind will assist us in determining eligibility and identifying your child's needs.

Describe the goods and/or services that, due to his/her disability, would benefit your child and explain why.

_____
_____
_____
_____
_____
_____

Please identify the daily challenges that your child faces in the following areas. If there is no challenge please indicate N/A (not applicable).

Self Care – age appropriate daily activities enabling a child to meet basic life needs for food, hygiene and appearance.

_____
_____
_____
_____

Receptive and expressive language – age appropriate communication involving verbal and nonverbal behavior enabling a child both to understand others and to express ideas and information to others.

_____
_____
_____
_____

Learning – age appropriate general cognitive competence and ability to acquire new behaviors, perceptions, and information; apply experiences to new situations.

_____
_____
_____
_____

Mobility – age appropriate ability to use fine and gross motor skills; ability to move one's person from one place to another with or without mechanical aids.

_____
_____
_____
_____

Self-direction – age appropriate management and taking control over one's social and personal life; ability to make decisions affecting and protecting one's self-interest.

_____
_____
_____
_____

Capacity for independent living – age appropriate ability to live without extraordinary assistance.

_____
_____
_____
_____

Economic self-sufficiency – age appropriate ability to function in the work place.

_____
_____
_____
_____

Is your child currently at risk of being placed out-of-home? ☐ Yes ☐ No

If yes, explain.

_____
_____

What times and days of the week are you generally available for a home visit?

☐ Monday Times available: _____

☐ Tuesday Times available: _____

☐ Wednesday Times available: _____

☐ Thursday Times available: _____

☐ Friday Times available: _____

Is there anything else that you would like us to know about your child and/or family?

_____
_____
_____
_____
_____

Parent/Guardian Signature: _____ Date: _____

_____

For office Use Only

Date Sent: _____ Staff Initials: _____

Date Received: _____ Staff Initials: _____

Home Visit Date: _____

Functional Screen Completed: _____

Eligible: ☐ Yes ☐ No Date: _____

Plan completed: _____