United Cerebral Palsy of Middle Tennessee
Rutherford County
P.O. Box 805
LaVergne, TN 37086-0805
Phone: 615-796-3341
Fax: 615-287-9139
Email: Laura_Crain@ucpnashville.org
Website: www.ucpnashville.org

Dear Applicant:

Thank you for your interest in the Rutherford County Family Support Program. The fund is made available through a grant from the State of Tennessee, and as such, certain eligibility requirements apply. Before you may be considered for assistance you must provide all of the information required in the application package.

Place all materials in the envelope provided (please make copies for your own records) and mail to us at the address above. Please make sure you have the appropriate postage on the envelope. You may also fax your materials to us at 615-287-9139. Requests are handled on a first come first serve basis. The earlier we receive your information, the sooner we will be able to assess your situation.

Once we have all the completed materials in hand, your application will go before the Rutherford County Family Support Council at their next scheduled meeting. This council makes determinations as follows:

1. Eligible – Allocation Amount Determined
2. Eligible – Waiting List
3. Not Eligible/Services Denied

Please be aware that we are not able to fund all requests. Each year, the Family Support Council develops a list of priorities that are utilized in consideration of applications. The determination regarding whether your request is appropriate for the program is made after eligibility review. Then, the Family Support Council determines the amount, if any, that we can allocate for your services. There is no guarantee that we will have funding available for all eligible applicants.

Please feel free to contact us should you have other questions.

Sincerely,

Laura Crain
Rutherford County Family Support Coordinator

Enclosure Checklist

Please use the following checklist to ensure all required items are enclosed before submitting application. Applications can not be considered without all requested information.

All applicants:

[ ] **Family Support Program Application**: Completed with all requested information.

[ ] **Documentation of Disability**: Letter or copy of any other document from a physician, therapist, school personnel, government agency or other professional that verifies that the applicant has the disability described in the application.

[ ] **Functional Limitations Form**: The Family Support Program is designed to serve persons with "severe disabilities." State law generally describes this as one or more disabilities that affect a minimum of three areas of functional capacity related to activities of daily living. This form may be completed by the applicant, or by a family member or caregiver who is familiar with how the applicant's disability affects his/her functional capacities.

[ ] **Documentation of Residency in Rutherford County**: In order to provide funding for Family Support services designated for Rutherford County, we must have documentation that the applicant lives in Rutherford County. Acceptable evidence would include copy of any of the following: utility statement, voter registration card, driver's license, or any government document with the name of the applicant (or applicant's head of household) and the applicant's street/home address. Please note: Post Office Box addresses are not acceptable evidence of residency.

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Family Support Program Application

Full name of Family Member with a Severe Disability	
Description/Type of Disability	
Age at which Disability was Acquired	Birth to 3 ❑ Age 3 to 22 ❑ after age 22 ❑
Social Security #	
Date of Birth	
Name(s) of Primary Family Member(s) in home/Individual(s) to contract regarding this application if other than person named above	
Family's Address City, State, Zip	
Tennessee County	
Phone	
Email (if available)	

Reason you are applying for Family Support Services (include information on the impact of disability on your family)

Describe the Support Services you need or are requesting:

Is the Individual or Family Currently Receiving Other Services?

Medicaid ❑ Medicare ❑ Private Insurance ❑

TN Div. of Mental Retardation ❑ TN Vocational Rehabilitation ❑

SSI ❑ TN Dept. of Mental Health ❑

Other:

In order to prevent discrimination (Title VI) the following information is needed:

Caucasian ❑ African-American ❑ Hispanic ❑ Other ❑

Male ❑ Female ❑

If Someone Other than the Family/Individual is making this Referral:

Name of individual making referral to Family Support	
Agency	
Address City, State, Zip	
Phone	
Email	

Please attach:

Document that verifies that the individual has the disability described above. This could be a letter from a professional such as a doctor, physical therapist, or teacher, copy of documentation from SSI, school or social worker or other reliable information that can be used as verification of disability.

Signature of Applicant or individual applying on behalf of applicant	Date

Functional Limitations

Name of Applicant: ______________________________________
Date: ______________________________________

Name of Person Completing this Form on behalf of Applicant: _________________________

The Tennessee Disability-Related Housing Assistance Fund is established to provide services to persons with specific functional limitations. Please complete the following information related to functional limitations of the individual applying for services:

Physical Limitations	**Yes**	**No**	**Child/Does not Apply**
Able to Walk with no Supports or Assistance?			
Able to Use Arms and Hands?			
Able to Sit Up without Supports?			
Able to transition from chair to standing, or from bed to standing position?			
Able to Dress without Assistance?			
Able to Eat Without Assistance?			
Able to go to the Bathroom Without Assistance?			
Able to Bathe Without Assistance?			
Able to see clearly enough to read? (If applicant wears correctives lens, can they see clearly when wearing glasses, contacts etc.?)			
Able to hear without hearing aid?			
Able to speak clearly enough to be understood by others?			

Behavioral Limitations	**Yes**	**No**	**Child/Does not Apply**
Able to behave in a generally socially acceptable manner without guidance and supervision			
Able to self-supervise (i.e., can be left alone for long periods of time)			
Able to self-regulate emotions/emotional behavior			
Able to comprehend and follow directions			

Life Skills Limitations	**Yes**	**No**	**Child/Does not Apply**
Able to earn a living or care for others			
Able to make critical decisions for himself/herself			
Able to conduct personal finances without assistance			

Please provide other information below or on a separate document that may be helpful in ascertaining the level of functional disability this individual has: