COMMUNITY LIVING SERVICES (CLS) APPLICATION AND AGREEMENT

Community Living Services Program Definition and Goals

Community Living Services provides direct payments to vendors or eligible individuals/families on behalf of an individual with a developmental disability living in the family home, or (for an adult) in either the family or his/her own home. The purpose of Community Living Services is to support the family's effort to maintain the health and safety of its family member with a developmental disability in the family home, thereby preventing out-of-home placement; or to support the health and safety of adults living in their own homes, thereby preventing placements in more restrictive settings.

Who is Eligible?

Anyone who is eligible to receive supports through the Division of Developmental Disabilities (Division) is eligible to apply for Community Living Services. In all cases, the individual or family members must:

- ✓ Show proof the support is not available through alternative programs or resources;
- ✓ Commit partial funding for the support, as required;
- ✓ Demonstrate a financial need for the assistance; and
- ✓ Develop a Individual Support Plan team approved plan to decrease the need for assistance if the request is for on-going support.

What Is and Is Not Covered?

Only authorized supports may be purchased with Community Living Services funds. Authorized supports are those recommended by the Individual Support Plan team and approved by the District Program Manager/Administrator or designee. The Division will only approve supports that can be purchased at a reasonable cost and support the health and safety of the individual.

Based on individual financial need, the amount of assistance will be determined by the District Program Manager/ Administrator or designee based on the recommendation of the Individual Support Plan team. On-going assistance may not exceed $400 per month and requests for one-time assistance may not exceed $4,800. Individuals may only request one-time assistance once per calendar year.

Community Living Services:

- ✓ Cannot be used to supplement the level of services already furnished to the individual or family under Division contracts with service providers;
- ✓ Cannot be used to purchase supports available under the Arizona Long Term Care System;
- ✓ Cannot be used to purchase food except physician recommended nutritional supplements not covered elsewhere;
- ✓ Is not available to people living in developmental or group homes except for people moving into a residential setting for the first time who need one-time assistance with essential items; and
- ✓ Is not available to individuals who have failed to take all reasonable steps to enroll in the Arizona Long Term Care System.

What Are the Funding Limitations?

Community Living Services is limited by Legislative Appropriation. The amount of funds requested for an individual will be determined by assessed need.

How Are Awards Determined?

All requests must show a positive benefit to the individual's health and safety. The District Program Manager/ Administrator or designee will consider the following factors:

- ✓ The availability of State funding;
- ✓ The likelihood that Community Living Services will support the family's integrity and prevent the need for residential placement or that it will foster smooth transition to more independence;
- ✓ The age and/or health status of the parents/family members;
- ✓ The complexity of the individual's needs, the stress which these place on the family as well as the family's ability to respond to that stress;
- ✓ The degree of individual/parental/familial participation in the cost of the support relative to their means;
- ✓ The anticipated duration of the need for funds; and
- ✓ The degree to which the individual/family is already receiving other Division funded supports and services.

See page 4 for EOE/ADA disclosures

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Individual's Name *(Last, First, M.I.)*: _____

Birthdate: _____ Age: _____ Area Code and Phone No.: _____

Individual's Address *(No., Street, City, State, ZIP)*: _____

Individual's ASSISTS Number: _____ Mailing Address *(If different)*: _____

Support Coordinator's Name: _____ Area Code and Phone No.: _____

Amount Requested: $ _____ Start Date: _____ End Date: _____

Program Eligibility *(Check all that apply)*: ☐ ALTCS ☐ DD ☐ SSI ☐ Other Health Insurance: _____

What will the funds be used for *(Must include a copy of two estimates for repairs, durable goods, etc. Only one estimate is needed for dental treatment. No estimate is required for assistance with incontinence supplies)*

Describe the reason(s) for requesting assistance *(List any extenuating circumstances such as health status, parental age, complexity of the individual's needs and the stress level this places on the family and their ability to respond to that stress)*

Describe the individual/family's financial contribution to the requested support

Attach the following:

☐ Proof of alternative resources explored and the outcome of those resource

☐ Plan to reduce the need for assistance over the next six months *(for requests for on-going funding)*

☐ Current bank account statement or ledger

☐ Current invoices for utilities *(gas, cable, electric, etc.)*

☐ Approved Service Plan

Community Living Services (CLS) payment(s) will be received by:

Payee's Name *(Vendor if possible)*: _____ FEI No.: _____

Payee's Address *(No., Street, City, State, ZIP)*: _____

INCOME					
HOUSEHOLD INCOME	**GROSS MONTHLY INCOME**	**ALIMONY/CHILD SUPPORT**	***OTHER** *(Nutrition Assistance (NA), Public Housing, etc.)*	**SSI/SSD**	**TOTAL INCOME**
INDIVIDUALS:	$	$	$	$	$ 0.00
ALL OTHERS:	$ 0.00	$	$	$	$ 0.00
**If you do not receive Nutrition Assistance (NA), please provide most recent date of application.*				**COMBINED TOTAL**	$ 0.00

LIST NAMES AND AGES OF ALL PERSONS DEPENDENT UPON THE INCOME IN THE HOUSEHOLD			
NAME	**AGE**	**NAME**	**AGE**

ALL HOUSEHOLD EXPENSES	
ITEM	**MONTHLY AMOUNT**
Mortgage/Rent	$
Auto	$
Phone	$
Utilities	$
Food	$
Insurance	$
Child Care	$
Credit Cards	$
Alimony	$
Child Support	$
Other *(Detailed list of expenditures)*	$
Other *(Detailed list of expenditures)*	$
Other *(Detailed list of expenditures)*	$
Exceptional Costs Associated with Care *(Specify)*	$
Total Expenses	$ 0.00
Total Income	$ 0.00
Total Discretionary Funds Per Month *(Income Minus Expenses)*	$ 0.00

Individual Support Plan Team Recommendation Regarding Request: _____

Support Coordinator's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Applicant/family agreement: I/we agree to use approved Assistance to Families funds according to this request. I/we agree to return to the Division all unspent funds received, and to furnish receipts to the Division documenting all expenditures within 30 days of receipt of the funds. Recipients must be pre-printed and specifically identify the support purchased. Under extenuating circumstances, handwritten receipts may be acceptable, but must include the name, address and phone number of the vendor as well as clearly identify the support purchased. I/we agree to notify the Division Support Coordinator in a timely manner of any changes in contributions, income or other circumstances that may affect this agreement. To the best of my knowledge, all information in this application is accurate.

Individual/Responsible Person's Signature: _____ Date: _____

☐ Request approved as submitted ☐ Revised amount approved: $ _____ ☐ Request denied

District Program Manager Administrator's Signature: _____ Date: _____

Deputy Assistant Director's Signature: _____ Date: _____