CLIENT SERVICES TRUST FUND

Client Services Trust Fund is a one-time assistance fund that was established to assist people with developmental disabilities and their families to reach their goal of increased independence. The Developmental Disabilities Advisory Council reviews and approves expenditures which meet the program goals.

Client Services Trust Fund Program Goals

The goals of the Client Services Trust Fund are to promote self-determination and provide for creative supports which increase participation in the community or improve an individual's quality of life.

Who is Eligible?

Anyone who is eligible to receive supports through the Division of Developmental Disabilities is eligible to apply for assistance. In all cases, the individual or family members must meet the following criteria:

- The requested item or support is not available through alternative programs.
- The individual or family member commits to contributing partial funding or in-kind supports.
- The individual or family member demonstrates financial need for assistance.
- People who are lawfully in the United States.

What is Covered?

The Council will review and authorize expenditures for single item one-time requests, up to the limit of available funds, that assist an individual to more fully participate in his/her community or improve the quality of life. The Client Services Trust Fund does not cover on-going funding needs such as rent subsidies or therapy payments. Requests for reimbursement will not be considered. Requests for payment for goods or services already received will not be considered.

What are the Funding Limitations?

Each year, the Council determines the maximum amount of funds available for the program. Members may make only one request per year. Requests can be made for single item purchases only.

Requests that are awarded must show evidence of shared cost and evidence that the member has exhausted other community and family resources.

The Council's award decisions are final.

Diapers: Adult briefs, diapers, and incontinence supply requests should be made through the member's health plan (ALTCS members). DD only and Targeted Support Coordination eligible members may apply for diapers through the Client Services Trust Fund.

How are Awards Determined?

Priority is given to:

- **Critical health / safety needs.**
- Promotes sustainable / independent living.

See page 2 for EOE/ADA/LEP/GINA disclosures.

Awards are prioritized with consideration given to:

- Amount of supports an individual already receives.
- Degree of financial need.
- Likelihood of funding to have a long-term positive impact.
- Demonstration that use of the Client Services Trust Fund will inhibit the member's need for residential placement that will foster a smooth transition to more independent living *(for an adult with a intellectual / developmental disability).*

How Do I Apply?

You must complete an application and a financial need statement. **You must include the names and ages of all people living in the household and the total household income and expenses.** Applications may be obtained through your Support Coordinator or by calling the Client Services Trust Fund Coordinator at 844-770-9500. Applications are reviewed two times per year. **Applications are due by March 1st and September 1st.**

The application process takes approximately 60 days from the application deadline. If awarded, applicants will receive a letter of award which will include any additional requirements to receive the funding. **Incomplete applications will not be considered for funding and will be returned to the applicant.** You may then reapply at the next award cycle with complete information. If your application is not approved for funding, you will be notified, however, all decisions are final and you may not appeal the decision.

Applicants should submit any additional documentation such as letters of justification to assist the Council in evaluating the request. Successful awards typically include more than one quote / estimate.

What Else Do I Need to Know?

Federal and state law requires the Division of Developmental Disabilities to verify the identity and U.S. citizenship or immigration status of people recommended to receive funds from the Client Services Trust Fund. Funds can only be issued on behalf of people who are lawfully present in the U.S. such as U.S. citizens, U.S. nationals or qualified aliens. If you are recommended for funding and are not eligible for AHCCCS or ALTCS, you will need to provide documentation of your identity and your citizenship or immigration status. If this applies to you, you will be notified to bring your documentation to the local office for verification. Submission of the required documentation is voluntary, however, awards will not be processed without the required verification.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Ayuda gratuita con traducciones relacionadas con los servicios del DES esta disponible a solicitud del cliente.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

CLIENT SERVICES TRUST FUND
APPLICATION FOR ONE-TIME ASSISTANCE

MEMBER'S NAME ______ BIRTH DATE ______ AGE ______ PHONE NO. ______

MEMBER'S ADDRESS *(No., Street)* ______

CITY ______ STATE ______ ZIP CODE ______

MEMBER'S ASSISTS NUMBER ______ MAILING ADDRESS *(If different)* ______

CITY ______ STATE ______ ZIP CODE ______

SUPPORT COORDINATOR'S NAME ______ PHONE NO. ______

AMOUNT REQUESTED $ ______ PROGRAM ELIGIBILITY *(Check all that apply)* ALTCS DD SSI

List all services/supports the member is currently receiving from the Division of Developmental Disabilities *(Check all that apply).*

Attendant Care	Habilitation
Housekeeping	Respite
Day Treatment Adult	Day Treatment Summer
Therapy	Nursing
Transportation	Employment Services
Room & Board	Other (Explain) ______

What will the funds be used for? *(You must include a copy of two estimates)*

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 member's cost contribution/in-kind support. *(List amount of financial contribution and/or the specific type of in-kind support offered.)*

Describe alternative resources explored, please be specific. *(Request for medical or dental funding must include a copy of medical provider's denial.)*

CLIENT SERVICES TRUST FUND FINANCIAL NEED STATEMENT

INCOME

HOUSEHOLD INCOME	GROSS MONTHLY INCOME	ALIMONY/CHILD SUPPORT	OTHER (Food Stamps, Public Housing, etc.)	SSI/SSD	TOTAL INCOME
MEMBER:					
ALL OTHERS:					
				COMBINED INCOME	

List names and ages of all persons dependent upon the income in the household.

NAME ______________________ AGE _____ NAME ______________________ AGE _____

NAME ______________________ AGE _____ NAME ______________________ AGE _____

NAME ______________________ AGE _____ NAME ______________________ AGE _____

ALL HOUSEHOLD EXPENSES

ITEM	MONTHLY AMOUNT
Mortgage/Rent	$ ________
Auto	$ ________
Home Phone	$ ________
Cell Phone	$ ________
Utilities	$ ________
Food	$ ________
Insurance	$ ________
Cable/Internet	$ ________
Child Care	$ ________
Credit Cards	$ ________
Alimony	$ ________
Child Support	$ ________
Other (Specify) ________	$ ________
Exceptional Costs Associated with Care (Specify) ________	$ ________
TOTAL EXPENSES	$ ________
TOTAL INCOME	$ ________
TOTAL DISCRETIONARY FUNDS PER MONTH *(Income minus expenses)*	$ ________

CLIENT SERVICES TRUST FUND AGREEMENT

Member/family agreement: I/we agree to use approved Client Services Trust 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. 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. I understand that reimbursement or payments for services already rendered will not be funded. To the best of my knowledge, all information in this application is accurate.

MEMBER/RESPONSIBLE PERSON'S SIGNATURE ______________________ DATE __________

MAIL COMPLETED FORM TO:

Arizona Department of Economic Security
Division of Developmental Disabilities
Client Services Trust Fund Coordinator, Mail Drop 2HA1
P.O. Box 6123
Phoenix, Arizona 85005-6123
FAX: (602) 542-2599