Office use only:
Date rec'd ____ ______
App. # FY_________

First In Families Application

Name of family member with disability:____

Address:_______________________________________ City__________________ Zip________

Residence Type: □ At Home □ Group Home □ Independently □ With Friends □ AFL □ Other ____________

County_________________ Phone (H)____________________(Other)_____________________

Date of birth:__________________ Race(Opt.):____________________Sex □ Male □ Female

(Asked to ensure we are reaching all ethnic groups in our area.)

What is this person's developmental and or mental health disability/diagnosis? _____________

How may FIF verify this diagnosis? ____

Parent/Guardian name:___________________________ Address:________________________

Other Contact/Case Manager__________________________ Phone: ______________________

How many people live in the home? _______Please list. ________________________________

What is the family's net income (**after taxes**) ?____________________ □ Per year □ Per month

Does anyone else in the home have a disability? □ yes □ no

Disability:	Name of Person:
___________________________________	___________________________________
___________________________________	___________________________________

The following services may be available in the community. Please check if you are receiving, on a waiting list, or have been denied any of the following:

If you would like to find out more about the below services or obtain a referral, please ask the FIF Staff or mention this in your request.

No	Receive	Wait	Denied	Service	No	Receive	Wait	Denied	Service
□	□	□	□	CAP	□	□	□	□	Respite Care
□	□	□	□	AFDC/TANF	□	□	□	□	In Home nursing
□	□	□	□	WIC	□	□	□	□	Supported Employment
□	□	□	□	SSI	□	□	□	□	Behavioral Mang.
□	□	□	□	Medicare	□	□	□	□	Developmental preschool
□	□	□	□	Medicaid	□	□	□	□	Before/after school care
□	□	□	□	SSDI/Social Security	□	□	□	□	Early Intervention
□	□	□	□	Vocational	□	□	□	□	Case Management
□	□	□	□	Speech therapy	□	□	□	□	Counseling
□	□	□	□	Physical therapy	□	□	□	□	Food Stamps
□	□	□	□	Occupational therapy	□	□	□	□	Other ____________
□	□	□	□	Residential					

Have you received FIF funds before? □ no □ yes
If "yes," under whose name?____
How did you hear about FIF?____

Please answer the following questions, attaching extra sheets if you would like:
What is your need? ____
____
____
____
What is your dream?____
____
____
____
Please describe in detail your request and be as specific as possible: ____________________
____
____
____
____
____
____
____

FIF hopes to build a network of resources for families like yours. If you have talents, gifts or items you'd like to share with other families in need, please identify them below.
____
____
____

By my signature below, I verify that the above information is accurate. I also give my consent for this information to be shared with members of FIF Management Team.

____ ____________________
Signature of responsible person Date

____
Printed name of responsible person

ADDITIONAL INFORMATION: Other agencies contacted concerning this matter and the results:
____
____
____