**Section 117.APPENDIX A Preliminary Application forms**

**Section 117.ILLUSTRATION A DMHDD-1235, Home-Based Support Services Program Application**

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| Illinois Department of Human Services |
|  |
| THE PRELIMINARY FAMILY ASSISTANCE PROGRAM APPLICATION |
|  |
| A new program for adults with a severe developmental disability or a severe mental illness. For more information call the Department's toll free number 1-800-843-6154.  |
|  |
| Please read the brochure before completing items 1-10 below, print or type clearly and sign the application:  |
|  | 1. | Applicant's name:  |  |
|  | 2. | Sex:  | [ ]  | Male | [ ]  | Female |  |
|  | 3. | Applicant's race | White | [ ]  | Black | [ ]  | Hispanic | [ ]  | Other | [ ]  |
|  | 4. | Applicant is believed to have: | [ ]  | severe autism; | [ ]  | severe mental illness; |
|  |  | [ ]  | severe or profound mental retardation; | [ ]  | severe and multiple impairments. |
|  | 5. | Applicant's birthdate:  |  | / |  | / |  |  |
|  | 6. | Applicant's social security number:  |  |
|  | 7. | Applicant's address:  |  |
|  |  |  | Street |
|  |  |
|  | City | State | Zip | County |
|  | 8. | Applicant's telephone number: |  |
|  | Area code | Number |
|  | 9. |  |
|  | a. | The applicant lives in his/her own home/apartment now:  |
|  | [ ] Yes  | [ ] No |  |
|  | b. | The applicant lives outside his/her home now but is a planning to move to his/her own home/apartment if chosen to participate in this program:  |
|  | [ ] Yes  | [ ] No |  |
|  | 10. | Applicant is enrolled in a special education program | [ ] Yes | [ ] No |
|  |  |
| I declare that the information above is true and I understand that if I am chosen this information will be confirmed by the Illinois Department of Human Services through an assessment to assure my eligibility to participate in the Home-Based Support Services Program.  |
|  |  |  |  |
|  | Applicant's or guardian signature | Date |
|  | Guardian's name |  |
|  | Guardian's telephone number: |  |
|  | Guardian's address: |  |

**Section 117.APPENDIX A Preliminary Application forms**

**Section 117.ILLUSTRATION B DMHDD – 1236, Family Assistance Program Application**

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| Illinois Department of Human Services |
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| THE PRELIMINARY FAMILY ASSISTANCE PROGRAM APPLICATION |
|  |
| A new program for adults with a severe developmental disability or a severe mental illness. For more information call the Department's toll free number 1-800-843-6154.  |
|  |
| Please read the brochure before completing items 1-10 below, print or type clearly and sign the application:  |
|  | 1. | Child's name:  |  |
|  | 2. | Sex:  | [ ]  | Male | [ ]  | Female |  |
|  | 3. | Child's race | White | [ ]  | Black | [ ]  | Hispanic | [ ]  | Other | [ ]  |
|  | 4. | I believe my child has: | [ ]  | severe autism; | [ ]  | severe emotional disturbance; |
|  |  | [ ]  | severe or profound mental retardation; | [ ]  | severe and multiple impairments. |
|  | 5. | Child's birthdate:  |  | / |  | / |  |  |
|  | 6. | Child's social security number (if available): |  |
|  | 7. | Parent's/guardian's Name: |  |
|  |  | Street address:  |  |
|  |  |
|  | City | State | Zip | County |
|  | 8. | Parent's/guardian's telephone number: |  |
|  | 9. | Family taxable income: | [ ]  under $50,000 | [ ]  over $50,000 |
|  | 10. |  |
|  | a. | My child lives in the family home now: | [ ]  Yes | [ ]  No |
|  | b. | My child lives outside the family home now, but if I am chosen to participate in this program I plan to bring my child back into the family home: |
|  |  | [ ]  Yes | [ ]  No |
|  | 11. | Is this a foster child: | [ ]  Yes | [ ]  No |
|  |
| I declare that the information above is true and I understand that if I am chosen this information will be confirmed by the Illinois Department of Human Services through an assessment to assure my eligibility to participate in the Home-Based Support Services Program.  |
|  |  |  |
| Parent/guardian signature |  | Date |