# First In Families of North Carolina

*Helping people with disabilities and their families to Believe in their dreams, Achieve their goals and Give back to others.*

Thank you for contacting **Mecklenburg First In Families** of North Carolina, a statewide 501(c)(3) that provides assistance to individuals with Developmental Disabilities (DD) or Traumatic Brain Injury (TBI) and their families. Mecklenburg First In Families, a project of InReach, is a catalyst for people with disabilities and their families in North Carolina to meet their self-determined needs by leveraging relationships and resources, and encouraging reciprocity in their communities.

Please complete the enclosed application and return to our office via fax, email, or regular mail. Be as specific as possible in explaining your self-defined need. If you have questions, please call the number below.

Once your application is received, you will be contacted within 3 business days to acknowledge its receipt. Each Chapter staff will determine eligibility and contact the applicant to acquire additional information if needed and discuss the request. You will be notified within 7 business days after your application has been reviewed for eligibility and processed.

To be eligible for assistance you must:

- have a combined household income not to exceed $65,000 after taxes;
- be or live with a family member with a developmental delay or intellectual/developmental disability or traumatic brain injury;
- live in Mecklenburg County - North Carolina; and
- place or residence must be a house or apartment, not a licensed setting

First In Families uses the NC statute 122-C-3(12a) to define developmental disability. A copy of this statute can be supplied for you if you wish.

Once eligibility is determined the Resource Consultant will work with you to clearly identify your need and find the sources for assistance. The goal of First In Families staff is to help you find what you need within the community and link you and/or your family member to those resources. This creates a partnership involving you, First In Families, and the community.

Please complete the enclosed application and return to:

**Mecklenburg First In Families**
***Attn: Keiba Young, Project Coordinator***
4530 Park Road
Suite 300
Charlotte, NC 28209
fifadministration@inreachnc.org
Phone: 704-536-6661 ext. 437
Fax: 704-536-0074

**Please Keep this Page** for your records

**First In Families of North Carolina Notice of Privacy Practices**

**This notice is effective April 14, 2003. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by law to protect medical information about you.**

We are required by law to protect the privacy of medical information about you and that identifies you. We are also required to give you this Notice about our Privacy Practices, explaining our legal duties and your rights concerning your health information. We must follow the privacy practices described in this Notice while it is in effect. We reserve the right to make changes to our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available on request. You may request a copy of our Notice at any time. If you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact the FIFNC staff at 919-251-8368. **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN CERTAIN CIRCUMSTANCES -We use and disclose health information about you for treatment, payment, and healthcare operations. Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you. **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization:** Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. **Disclosures to You, to Your Family, or to Your Friends:** We must disclose your health information to you in accordance with the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you authorize us to do so. **Persons Involved in Your Care:** We may use or disclose health information to notify, or assist others in notifying a family member, your personal representative or other person responsible for your care, of your location, your general condition, or death. If you are present, we will provide you with an opportunity to object to such disclosures of your health information prior to use or disclosure of that information. In the event you become incapacitated or have a medical emergency, we will disclose your health information based on our professional judgment that such disclosure is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and experience to make decisions about your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization. **Required by Law:** We may use or disclose your health information when we are required to do so by law. **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you may be the victim of abuse, neglect, domestic violence or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. **National Security:** May disclose to military authorities the health information of Armed Forces personnel under certain circumstances. May disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances. **Appointment Reminders:** May disclose health information to provide you with appointment reminders (voicemail messages, postcards or letters). **PATIENT RIGHTS - Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make this request in writing to obtain access to your health information. You may obtain a form to request access from your care provider. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. For details about when this request may be denied, please speak with your care provider. **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. **Amendment:** You have the right to request that we amend your health information. (Request must be in writing, and must explain why the information should be amended.) We may deny your request under certain circumstances. **Electronic Notice:** If you receive this Notice on our Web site or by electronic mail, you are entitled to receive this Notice in written form upon request. **QUESTIONS AND COMPLAINTS:** If you want more information about our privacy practices or have questions or concerns, please contact your health care provider or FIFNC staff at 919-251-8368. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **Questions and Complaints ® (919) 251-8368.**

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# Mecklenburg First In Families, *a project of InReach* - Application

## 1. Family/Guardian/Self-Advocate Household Information

Please select one:

☐ Parent ☐ Applicant ☐ Guardian

Name_____E-mail_____

Address_____ City_____ Zip_____

County _____ Phone_____☐ Cell ☐ Home ☐ Work Other Phone_____ ☐ Cell ☐ Home ☐ Work

a. How many adults are living in the home?____ b. How many teens/children are living in the home?____

c. How many adults over 65 years living in the home? ____ d. Adults with disabilities (18 and up) who live in the home?__

e. Is anyone in the home on Medicare? ☐ Yes ☐ No f. Are there active/former military living in the home? ☐ Yes ☐ No

g. Are you a grandparent raising your grandchildren? ☐ Yes ☐ No h. How did you hear about us? _____

i. Have you received assistance from First In Families before? ☐ Yes ☐ No j. Have you experienced a crisis in the past 6 months? (i.e. ER visits, homelessness, domestic violence, crisis services provided by LMEs/MCOs) ☐ Yes ☐ No

k. We offer future planning services for families. Would you like to be contacted about any future planning question (wills, special needs trusts, etc.)? ☐ Yes ☐ No l. Are you interested in learning more about NC Sibs, a network that supports adult siblings of individuals with disabilities? ☐ Yes ☐ No

## 2. Household Income:

| Income** | How often? |
|---|---|
| $_____ | ☐ Weekly ☐ Monthly ☐ Yearly |
| | |
| **Child Support** | **How often?** |
| $_____ | ☐ Weekly ☐ Monthly ☐ Yearly |
| **SSDI and/or SSI** | **SNAP/FoodStamps/EBT** |
| $_____ | $_____ |

** Please include income for all individuals in the home. Take home pay OR adjusted gross income from tax return.

## 3. Information on Individual with the Developmental Disability or Traumatic Brain Injury

Name:_____

Address: _____City_____ State____ Zip_____

(if different)

☐ Male ☐ Female | Date of Birth: ___/___/___ Race/Ethnicity (Optional)* _____

Residence Type:

☐ At Home | ☐ Group Home ☐ Independently

☐ AFL | ☐ Other_____

**Asked to ensure we reach all racial and ethnic groups in our area*

## 4. Diagnosis

Please check the box(es) for any available diagnosis information.

- ☐ At Risk for Dev. Delay (Ages 0-3 only)
- ☐ Developmental Delay (Ages 0-4 only)
- ☐ Speech Delay
- ☐ Motor Delay
- ☐ Autism Spectrum Disorders
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Fetal Alcohol Spectrum Disorder
- ☐ Fragile X
- ☐ Intellectual Disability
- ☐ Muscular Dystrophy
- ☐ Spina Bifida
- ☐ Traumatic Brain Injury
- ☐ Atypical
- ☐ Other/Secondary Diagnosis:

How may we verify the diagnosis?

## 5. Current Services Received

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: *(Note: If you would like to find out more about the below services or obtain a referral, please ask FIF Staff.)*

| Service | Circle the correct response for each service | | | |
|---|---|---|---|---|
| AFDC/WIC/Food Stamps | No | Receive | Waitlist | Denied |
| Behavioral Mgmt. | No | Receive | Waitlist | Denied |
| CAP-C | No | Receive | Waitlist | Denied |
| CAP-DA | No | Receive | Waitlist | Denied |
| Innovations/CAP-MR/DD | No | Receive | Waitlist | Denied |
| Early Int./Dev. Preschool | No | Receive | Waitlist | Denied |
| Medicaid | No | Receive | Waitlist | Denied |
| Medicare | No | Receive | Waitlist | Denied |
| OT/PT/Speech | No | Receive | Waitlist | Denied |
| Residential Supports | No | Receive | Waitlist | Denied |
| Respite | No | Receive | Waitlist | Denied |
| Section 8 Housing | No | Receive | Waitlist | Denied |
| Special Education | No | Receive | Waitlist | Denied |
| SSDI | No | Receive | Waitlist | Denied |
| SSI | No | Receive | Waitlist | Denied |
| Vocational Rehab. | No | Receive | Waitlist | Denied |
| TBI Medicaid Waiver | No | Receive | Waitlist | Denied |

What kind of insurance does the individual requesting assistance currently have? (Check all that apply)

☐ Medicaid ☐ Medicare ☐ Other Health Insurance

Other Contact:_____Phone/Email:_____

(Case Mgr, Care Coordinator, QP, Community Guide)

May we talk with him/her about your application? ☐ Yes ☐ No

## 6. Please answer the following questions, attaching extra sheets if you would like:

What is your need? (Please provide as much detail as possible, including vendors and prices if applicable).

_____

_____

_____

## Meckleburg First In Families Checklist – Submit to Fax: 704.536.0074 or fifadministration@inreachnc.org

- Proof of Mecklenburg County residency (photo ID or current utility bill or signed lease agreement)
- Proof of all household income (4 weeks of pay stubs and/or SSI award letter and/or Snap benefits award letter and/or current 1040 tax return)
- Proof of developmental delay or disability (psychological evaluation, diagnostic assessment or medical record)
- Provide copy of vendor information (i.e., summer camp registration, 1-2 price quotes or invoices)

*By my signature below, I verify that the above information is accurate. My signature on this application also indicates that I understand that I may receive a survey from First In Families of North Carolina asking me to give feedback on the FIF program. I understand that if I choose to complete the survey, those survey results may be shared (anonymously) with others.*

_____ _____ _____

Print Name | Signature of Parent/Guardian/Self-Advocate | Date

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## Consent to Release Information

Applicant's Name:_____ D.O.B._____

(insert information for the Individual with a developmental delay or disability)

I hereby authorize First In Families of North Carolina to share and receive both written and verbal information regarding the above-named applicant and his/her resource needs. This information will be used for the purposes of identification of resources to meet needs identified by the family/individual.

☐ CDSA (Child Development Service Agency)
☐ Local Management Entity
☐ Physician(s):_____
☐ Occupational/Physical/Speech Therapists
☐ School: _____
☐ Child Care Program:_____
☐ Other:_____

Such information may include medical, psychological, social and other pertinent information concerning the above named. I understand that this permission shall remain valid for one (1) year from the date of my signature. However, I may revoke this permission at any earlier time by written notice to First In Families of North Carolina except for action already taken.

_____ _____

Signature of Self Advocate/Parent/Guardian | Date

_____ _____

Witness | Date

## WE ENCOURAGE THOSE WE SERVE TO GIVE BACK

Are there any talents/items you would like to share with First In Families?

☐ Advocacy | ☐ Fundraising | ☐ Letters to Legislators |

☐ Moving Furniture | ☐ Handyman/Carpentry Skills |

☐ Parent Support | ☐ Volunteer (Chapter Projects)|

☐ Volunteer (Management Team) |

☐ Clothing/Toys/Equipment to donate

☐ Other_____

## First In Families of North Carolina Notice of Privacy Practices

First In Families of North Carolina Notice of Privacy Practices - This notice is effective April 14, 2003 I acknowledge that I have received a copy of the FIFNC Notice of Privacy Practices.

_____ _____

Signature of Self-Advocate/Parent/Guardian | Date

**Need help with this application?** Feel free to call Mecklenburg Chapter Staff, Keiba Young, 704-536-6661 ext. 437 or visit www.fifnc.org to find the chapter in your area.

Updated: 12/21/2018