# 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 and their families to meet their self-defined needs. **Mecklenburg First In Families, a project of InReach** is a catalyst for individuals' and their families in North Carolina to meet their needs by leveraging relationships and resources, and encouraging "giving back" in their communities.

☐ Please complete the enclosed application and return to our office via fax, email, or regular mail with all **supportive documents (i.e., proof of income, proof of residency, and/or vendor invoice). For new applicants only, please also provide proof of the intellectual/developmental disability.** 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 from a **Private/Restricted Phone Number** or an email to acknowledge its receipt. Staff will determine eligibility and contact the applicant to acquire additional information if needed and to discuss the request. You will be notified within 7 business days after your application has been reviewed for eligibility.

☐ Once eligibility is determined, the Resource Director 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 secure what you need within the community and connect you and/or your family member to those resources. This creates a partnership involving you, First In Families, and the community.

Income eligibility is based on the household size and 300% of the Federal Poverty Guidelines (FPG), see chart below.

| Family Size | 300% FPG |
|---|---|
| 1 | $40,770 |
| 2 | $54,930 |
| 3 | $69,090 |
| 4 | $83,250 |
| 5 | $97,410 |
| 6 | $111,570 |
| 7 | $125,730 |
| 8 | $139,890 |

Please complete the enclosed application and return to:

**First In Families of Mecklenburg County**
***A project of InReach***
Phone: 704-536-6661 EXT. 437
Fax: 704-536-0074
Email: fifadministration@inreachnc.org
4530 Park Road, Suite 300
Charlotte, NC 28209

**Please Keep this Page**

**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.**

**Please Keep this Page**
For your records

Rev. 2/22/2022, Rev. 9/20/2022

# Mecklenburg First In Families - Application

Internal Use Only
**Date Rec'd:**
**Initials:**

## 1. Family/Household Information

Who is completing this application? ☐ Applicant ☐ Parent/Guardian ☐ Other_____

Name_____ Email_____ County:_____

Address:_____ City:_____ State:_____

Zip:_____ Phone_____ ☐ Cell ☐ Home | 2nd Phone_____ ☐ Cell ☐ Home

Secondary Contact:_____ Phone:_____ Email:_____
(Case Mgr, Care Coordinator, etc.) May we talk with them about your application? ☐ Yes ☐ No

**How many are living in the home?**

Adults:_____ Children/Teens:_____ Adults **over 65**:____ Adults with **disabilities** (18 and up):_____

a. How did you hear about us?/ Who or what organization referred you? _____
b. Have you, or anyone in your house, served in the Military? ☐ Yes ☐ No
c. Are you a grandparent raising your grandchildren? ☐ Yes ☐ No

## 2. Household Income

| Income** | How often? |
|---|---|
| $ | ☐ Wkly. ☐ Mthly. ☐ Yrly. |
| **Child Support** | **How often?** |
| $ | ☐ Wkly. ☐ Mthly. ☐ Yrly. |
| **SSDI and/or SSI** | **SNAP/Food Stamps/EBT** |
| $ | $ |

*** Please include net income for ALL people in the home.*

*Have you, or anyone in your house, received a diagnosis of a developmental disability, delay, or Traumatic Brain Injury or Severe and Persistent Mental Illness?*
☐ **Yes - Continue to Section 4**
☐ **No - Skip 4, Continue to Section 5**

## 3. Information on Individual/Applicant

Name:_____

☐ Male ☐ Female ☐ Non-Binary

Date of Birth: _____/_____/_____ Race:_____

**Residence Type:** ☐ At Home | ☐ Group Home | ☐ Independently ☐ AFL | ☐ Other

Address (if different) : _____City_____ Zip_____

**Which health coverage does the applicant have?**

☐ Medicare | ☐ Private Insurance | ☐ No Insurance
☐ Medicaid (Choose Insurance Provider)
☐ AmeriHealth Caritas | ☐ Healthy Blue | ☐ UnitedHealthcare
☐ Well Care ☐ Carolina Complete Health | ☐ Medicaid Waiver
☐ Unsure

## 4. Disability Diagnosis

Please check any diagnosis(es) the applicant has.

| Diagnosis |
|---|
| ☐ 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 |
| ☐ Severe & Persistent Mental Illness |
| ☐ Substance Use Disorder |
| ☐ Other/Secondary Diagnosis: |
| **How may we verify the diagnosis (Required)?** |

## 5. Current Services Received

The following services may be available in the community. Please check if you are receiving or on the waiting list for any of the following.

| Service | Receive | Waitlist |
|---|---|---|
| SNAP/Food Stamps/EBT | | |
| Behavioral Mgmt. | | |
| CAP- C Medicaid Waiver | | |
| CAP- DA Medicaid Waiver | | |
| Innovations/CAP- IDD Medicaid Waiver | | |
| Early Int./Dev. Preschool | | |
| OT/PT/Speech | | |
| Residential Supports | | |
| Respite | | |
| Section 8 Housing | | |
| Special Education | | |
| SSDI | | |
| SSI | | |
| Vocational Rehab. | | |
| TBI Medicaid Waiver | | |

**Have you or anyone in your household experienced a crisis in the past six months?** ☐ Yes ☐ No

**Currently or within the past 6 months have you/anyone in your household experienced?**

☐ Food Insecurity ☐ Interpersonal Violence ☐ Unreliable Transportation ☐ Homelessness
☐ Mental Health Crisis ☐ Major Medical Illness/Expense ☐ Loss of Employment/Income
☐ Cultural/Language Barriers ☐ Death of Caregiver/Household Member ☐ Natural Disaster
☐ Transition from Foster Care, Group Home, Shelter, Prison

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

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

~~May we contact the vendor on your behalf? ☐ Yes ☐ No~~

## WE ENCOURAGE THOSE WE SERVE TO GIVE BACK!

**Are there any talents/items you would like to share with First In Families?** *(SOME EXAMPLES ARE BELOW)*

☐ Advocacy ☐ Fundraising ☐ Letters to Legislators
☐ Moving Furniture ☐ Handyman/Carpentry Skills ☐ Parent Support
☐ Volunteer (Chapter Projects) ☐ Volunteer (Management Team) ☐ Clothing/Toys/Equipment to donate
☐ Other:

*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.*

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.*

_____ _____ _____
Print Name Signature of Applicant/Guardian Date

## CONSENT TO RELEASE INFORMATION

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.

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 NC except for action already taken.

Applicant's Name:_____

D.O.B._____

_____ _____
Signature of Applicant/Guardian Date

_____ _____
Witness Date

# First In Families of Mecklenburg County

***A project of InReach***

**4530 Park Road, Suite 300 • Charlotte, NC 28209 • (704) 536-6661 • (704) 536-0074 Fax**


## AUTHORIZATION FOR USE OF PERSONAL PHOTOGRAPH

Individual Name: _____
(print clearly)

Request Number:_____

I hereby authorize **InReach/First In Families** and its affiliates to use the photographic or video image of the above named person & surrounding individuals in the image for training and/or publicity purposes. I understand that the photographic image may appear in printed publications, displays, or video presentations. This release allows for the use of photographs or video images by InReach/First In Families and its affiliates and allows InReach/First In Families and its affiliates to permit photographs and video images to be taken and published in newspapers or other printed media and/or shown on television. The name of the person & surrounding individuals in the image may or may not appear in the photograph or video image depending on the situation.

_____
Individual or Legal Guardian signature

_____
Witness if signed by a mark

_____
Date Signed