

**IOWA DEPARTMENT OF HUMAN SERVICES
STORY COUNTY
CHILDREN-AT-HOME
APPLICATION PACKAGE**

Attached is an application for you to receive assistance through the Children-At-Home program. The Children-At-Home program is designed to assist you and your family in securing the services and supports that you identify as necessary in helping your child remain at home. An underlying principle of the Children-At-Home program is that you and your family retain control of decisions that affect your child and family. Financial assistance is intended to enable you to obtain those services and supports that are not met by other services/programs.

To qualify for the Children-At-Home program:

- You and your family must reside in the state of Iowa and in Story County.
- Your family must include a child with a disability, which is defined as an individual who is less than twenty-two years of age and meets the definition of developmental disability.
- Your family's intent is to secure those services and supports which would enable your child to remain living in the family home.
- Your family's federal net (not gross) taxable income for the most recent tax year is less than \$60,000.

If you have any questions about this program or want to apply for assistance, please contact:



Jay D. Lettow
Executive Director / CAH Resource Coordinator
The Arc of Story County
PO Box 581 430 Fifth St.
Ames, IA 50010
Phone: (515) 232-9330
info@thearcstory.org
www.thearcstory.org

** We recommend that you make a copy of this completed application for your own records. You should also keep the cover page and page of information on the effect of CAH on other programs/income.

Effects of Children-At-Home Assistance on Other Programs/Income

On Income Tax:

According to an Internal Revenue Service Advisory Opinion, income received pursuant to assistance under the Children-At-Home program is not taxable for Federal Income Tax purposes to the extent that the subsidy does not exceed actual expenses incurred for the care of the family member.

On Family Investment Program (FIP) (formerly known as ADC):

If you receive FIP payments, assistance received under the Children-At-Home program should not affect your eligibility, provided you do not use the subsidy for your own basic needs of shelter, utilities, household supplies, food, clothing, personal care and supplies, medicine chest items, bus fares, telephone, newspapers and magazines. You may not use the subsidy for the special needs which include school expenses, guardianship/conservator fees, the expenses of Individual Education and Training Plan programs, and child care while enrolled in a Job Training Partnership Act training plan. If you have questions regarding your FIP benefits, talk to your income maintenance worker.

On Supplemental Security Income (SSI):

It is our understanding that the assistance received under the Children-At-Home program would not be counted in determining income eligibility. If you have questions regarding this, contact the Social Security Administration office.

On U.S. Department of Housing and Urban Development (HUD), Section 8:

It is our understanding that HUD will not consider assistance received under the Children-At-Home program as income when determining participation in the Section 8 program.

On Food Stamps:

Assistance received under the Children-At-Home program is considered income for Food Stamps. If you have questions regarding your Food Stamps, talk to your income maintenance worker.

On Medicaid and Medicaid Home and Community Based Services Waivers:

Being on the subsidy does not effect your eligibility for these programs and being on these programs does not effect your eligibility for assistance received under the Children-At-Home program.

Others:

If you apply for any services or programs that require income verification and you would like them to not consider your subsidy payment, please contact:

Children-At-Home Program
Dept. of Human Services – Division of ACFS
5th Floor, Hoover State Office Building
Des Moines, Iowa 50319-0114
Phone: 515-281-5338

Information will be provided to the service or program and a request will be made that the subsidy payment not be considered as income.

IOWA DEPARTMENT OF HUMAN SERVICES
STORY COUNTY
APPLICATION FOR CHILDREN-AT-HOME
SERVICES & FAMILY SUPPORTS

1. FAMILY INFORMATION

Child's Name: _____
Last First MI

Date of Birth

Parent's Name: _____
Last First MI

Parent's Name: _____
Last First MI

Family's Address: _____
Street/PO Box

City State Zip

County Home Phone

Email Address

We live on/in a:

- Farm Homestead Town (population less than 5,000)
 Town (population less than 10,000) City (population less than 100,000)
 Metropolitan (population over 100,000)

Racial/Ethnic Heritage child identifies with (optional): _____

2. FAMILY'S TAXABLE INCOME

Check the space which indicates your family's **federal net taxable income*** for the most recent tax year.

\$9,999 and under \$10,000-19,999 \$20,000-39,999 \$40,000-\$60,000

*A signed copy of your federal income tax return from the most recent tax year must be submitted with this request. Do not submit any of the attachments or schedules. Please provide other proof of income if you do not file taxes, this may include, a paycheck stub, a Title 19 paycheck stub, or a FIP or SSI award letter that states your income. The copy of the tax return, or other income verification, will be kept on file.

YOUR APPLICATION WILL NOT BE PROCESSED UNTIL INCOME VERIFICATION IS PROVIDED.

3. CHILD’S DISABILITY

Please list your child’s disability(s). If your child’s disability is rare please include a brief description.

Please check the services your child currently receives for his/her disability:

- | | |
|---|--|
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Nutrition Services |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Individualized Education Plan (IEP) |
| <input type="checkbox"/> Music Therapy | <input type="checkbox"/> Individualized Family Service Plan (IFSP) |
| <input type="checkbox"/> Special Education Services | <input type="checkbox"/> Other |

If you checked “other” please explain:

4. FAMILY’S IDENTIFICATION OF SERVICES AND SUPPORTS

Indicate with an “X” the specific services or supports that you feel would benefit your family and for which you are requesting financial assistance. The list is not intended to be an exhaustive list – include services not listed here in the “other” category.

- | | | |
|--|--|---|
| <input type="checkbox"/> Adapted Clothing | <input type="checkbox"/> Insurance | <input type="checkbox"/> Special Foods |
| <input type="checkbox"/> Adaptive Equipment | <input type="checkbox"/> Parent Education/Counseling | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Counseling for my child | <input type="checkbox"/> Recreation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Home Modification | <input type="checkbox"/> Respite Care/Child Care | <input type="checkbox"/> <i>Emergency</i> |

Item needed for your family/ child	Who is to be reimbursed?	Total Cost	CAH funds needed

I declare that this information is true to the best of my knowledge. My family resides in the state of Iowa. My child has a disability and it is my intent to have my child remain living in my home. Services and supports purchased with these funds will not be used to supplant other services and support available to my family including Medicaid (Title XIX) and the Family Investment Program (FIP). I hereby release and waive any and all liability from the Decategorization Project and designated administering agency for services, supports, equipment and all other items funded fully or partially through the Children-At-Home program.

Signature of Applicant

Date

**DEPARTMENT OF HUMAN SERVICES
CHILDREN-AT-HOME PROGRAM
VERIFICATION OF DISABILITY
PAGE 1 OF 2**

If your child is receiving services from one of the programs listed below, your family is deemed to have met the eligibility criteria of having an individual with a disability residing in their home:

Early intervention (for children birth to age three – child has an Individualized Family Service Plan – IFSP)

Name of Service Coordinator/Agency: _____

Home & Community-Based Waiver Services

CIRCLE: MR waiver Ill & Handicapped waiver Brain Injury Waiver

Name of Case Manager/County: _____

Supplemental Security Income (SSI)

If your child is **NOT** receiving services from a program listed above, you will need to obtain verification that your child meets the definition of developmental disability (see page 7 of this application). The signature may be from any of the following professionals who are knowledgeable of your child's disability: Medicaid case manager; occupational or physical therapist; physician; school psychologist; school social worker; or vocational rehabilitation counselor.

If you are not receiving the services listed above please answer the following questions:

Are you in the process of getting Early Intervention/ IFSP, Home & Community-Based Waiver Services, or Supplemental Security Income (SSI)?

Yes

No

Are you interested in signing up for Early Intervention/ IFSP, Home & Community-Based Waiver Services, or Supplemental Security Income (SSI) but need further information or assistance?

Yes

No

**DEPARTMENT OF HUMAN SERVICES
CHILDREN-AT-HOME PROGRAM
VERIFICATION OF DISABILITY
PAGE 2 OF 2**

If your child is **NOT** receiving services from a program listed on page 6, you will need to obtain verification that your child meets the definition of developmental disability. The signature may be from any of the following professionals who are knowledgeable of your child's disability: Medicaid case manager; occupational or physical therapist; physician; school psychologist; school social worker; or vocational rehabilitation counselor.

The Children-At-Home program is designed to provide supports and defray costs of caring for children at home for families who are not being serviced or are being underserved through other service delivery or payment systems. In order to determine eligibility for the Children-At-Home Program, your help is requested in verifying our child's disability. I authorize the release of information related to my child's disability.

Name of Child: _____

Date of Birth: _____ SSN: _____

Parent's Signature: _____

The above-named child has a developmental disability as defined in 42 U.S.C d 6001. Persons with developmental disabilities have severe, chronic conditions that:

1. are attributable to a mental or physical impairment or combination of mental and physical impairments;
2. are manifested before the person attains age 22;
3. result in substantial functional limitation in three or more of the following areas of major life activities: self care, receptive and expressive language, learning, mobility, self-direction capacity for independent living, economic self-sufficiency;
4. and reflect the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated; except that such term, when applied to infants and young children means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

PROFESSIONAL CERTIFICATION:

I hereby verify that the above-named child has a developmental disability as defined above.

Signature

Title or license number

Date