**FAMILY SUPPORT PROGRAM APPLICATION**

Division of Behavioral Health

**CLINICAL INFORMATION**

Mental Health Provider:       Clinician/Systems of Care Coordinator’s Name:

Address:       Email Address:       Work Phone:

**CLIENT INFORMATION**

Client’s Name:       Male Female DOB:

Is the client a South Dakota resident? Yes No

Race: White Black Hispanic American Indian Alaskan Native Asian Pacific Islander   
Other

Service Program: CYF FFT ART MRT JJRI (SOC) Project AWARE-SEA (SOC)

CYF, FFT, ART, MRT or JJRI (SOC)

Is the client currently involved with the juvenile justice system? Yes No

* + If yes, explain the involvement.
  + If no, explain why the client is at risk for involvement with the juvenile justice system and how they may be diverted with the aid of Family Support funds.

Project AWARE-SEA (SOC)

Explain the client’s unmet needs, reason for referral and how accessing Family Support funds will improve any challenges related to their mental health.

**REQUESTED SUPPORT INFORMATION**

With the application, submit the following information:

1. Describe the request.
2. Provide an itemization of the requested support.
3. Explain how the request is tied to the client’s treatment plan, JJRI (SOC) or Project AWARE-SEA (SOC) identified needs.
4. Explain what the client/family will be doing to support their needs after funding is utilized through this program (i.e. budgeting classes, seeking employment, etc.)
5. Explain what other community or state resources have already been utilized or pursued and what happened.
6. Does the client meet financial eligibility requirements? Yes No *(Submit a copy of the client’s Means Financial Eligibility 101 form)* 
   * If financial eligibility requirements are NOT met, explain why paying for this request would be an undue financial burden for the client?

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| **INTENDED OUTCOMES**  *Check only those that apply to this request.*  **Hospitalizations** *(check only one)*  The client has gone to the emergency room or has been hospitalized within the last 30 days due to declining mental health issues.  The client has experienced a decline in mental health within the last 30 days and as a result, is at imminent risk of hospitalization due to those mental health issues. *(Imminent risk is the expectation that hospitalization will occur in the immediate future without intervention or assistance.)*  **Child Protective Services (CPS)** *(check only one)*  The client has experienced a decline in mental health and as a result, has been reported to or investigated by CPS within the last 30 days.  The client has experienced a decline in mental health within the last 30 days and as a result, is at imminent risk of being involved with CPS. *(Imminent risk is the expectation that CPS involvement will occur in the immediate future without intervention or assistance.)*  **Housing** *(check only one)*  The client has been actively seeking housing within the last 30 days.  The client has experienced a decline in mental health within the last 30 days and as a result, is at imminent risk of losing their housing and/or utilities. *(Imminent risk is the expectation that homelessness will occur in the immediate future without intervention or assistance.)*  **Basic Needs**  The client has experienced a decline in mental health within the last 30 days and as a result, has not been able to provide or afford basic needs and all other resources have been exhausted. Basic needs include personal hygiene products, household cleaning supplies and products; furnishings, bedding, cooking utensils and appliances.  **Continuing Education** *(i.e. obtaining GED, pursuing secondary education)*  The client has been actively attempting to further their education within the last 30 days and their mental health service plan has a treatment goal to support this.  **Educational Supports**  The client has experienced a decline in mental health within the last 30 days resulting in significant school absences, declining grades and/or relational problems with peers and teachers and their treatment plan has a goal to address this.  **Specialized Equipment**  The client has been experiencing a decline in mental health within the last 30 days and it has been identified through their treatment plan that their mental health would benefit from sensory integration equipment, STEM learning toys and/or other adaptive equipment. The family/client cannot otherwise afford this, and all other funding sources have been exhausted.  **Community Involvement**  The client has been struggling with isolation, peer relationships and/or lack of community involvement that has affected their mental health within the last 30 days and their treatment plan has a goal to address this.  **Health** *(check only one)*  The client has experienced a decline in mental and physical health within the last 30 days and needs opportunities to increase their level of activity and their treatment plan has a goal to address this.  The client has experienced a decline in mental and physical health within the last 30 days due to lack of dental and/or eye care that the client otherwise cannot afford and is beyond coverage through Medicare, Medicaid or private insurance and their treatment plan has a goal to address this.  **Self-Harm**  The client has experienced incidences of self-harm and/or has attempted suicide within the last 30 days and has an active crisis intervention plan to address this.  **Family Involvement**  The client has experienced significant family relational problems within the last 30 days which has affected their mental health and their treatment plan has a goal to address this. |

**CLINICIAN’S SIGNATURE** **DATE**

*I understand for individuals to be eligible for the Family Support Program they must be a South Dakota resident, receiving services through a mental health provider and meet the required financial eligibility requirements. I hereby attest that this information is true and correct and that the individual/family meets the eligibility requirements for the Family Support Program.*

Submit the completed application, Means Financial Eligibility 101 form and other supporting documentation to:

**Department of Social Services, Division of Behavioral Health  
Family Support Program**

**Kneip Building**

**c/o 700 Governors Drive**

**Pierre, SD 57501-5070**

**Phone Toll-Free 855-878-6057 or 605-773-3123**

**FAX 605-773-7076**