



Family Support Program

CLINICAL INFORMATION

Mental Health Provider: _____ Clinician's Name: _____
Provider's Address: _____
Phone Number: _____ Email Address: _____

CLIENT INFORMATION

Client Name: _____ DOB: _____
South Dakota Resident?
Gender: _____ Race: _____
Service Program: _____

Is the client currently involved with the Juvenile Justice?

YES	If yes, explain the involvement:
NO	If no, explain how the client may be at risk for involvement:

INFORMATION

1. List items being requested. Provide documentation (i.e., estimate from business, copies of past due bills).
2. List the total cost associated with each item. Include applicable taxes, delivery fees, etc. Online orders, add a reasonable amount to the request to safeguard against changing prices.
3. Describe the circumstances involving why the family needs assistance with the request.
4. Describe how the request is tied to the client's treatment plan.

5. Describe what the family will be doing to financially support their needs after funding is utilized through the program? (i.e., budgeting classes, seeking employment).

6. This program is funding of last resort. All other funding sources shall be exhausted before financial assistance is requested through the program.
Describe what other funding sources were accessed at the community or state level and the result.

7. Does the client meet financial eligibility requirements?
(Provide a copy of the client's Financial Eligibility 101 form).

If financial eligibility is NOT met, explain why paying for this request would be an undue financial burden for the client?

INTENDED OUTCOMES

<i>Only check those that are most important and relate specifically to the requested support. Check a minimum of ONE or up to a maximum of THREE.</i>		
	Basic Needs	The client needs basic items such as dental/eye care, food, transportation, clothing, hygiene products, household cleaning supplies, furnishings, appliances or other household items.
	Housing/Utilities	The client's family is not able to secure first month's rent or rental deposit; or are at risk of losing their housing due to past due rent or utility bills.
	Education	The client needs items such as school supplies or clothing, transportation to/from school, or items for school-based activities.
	Specialized Equipment	The client would benefit from sensory integration equipment, STEM learning toys and/or other adaptive equipment.
	Community	The client would benefit from activities that would reduce isolation, promote peer relationships and other social supports; increase community involvement and physical activity.
	Family	The client is experiencing family relational problems and activities/programming have been identified to improve family development and well-being.
	Health	In the past 30 days, the client has had emergency room visits, hospitalizations, instances of self-harm or suicidal ideation/attempts.
	CPS / Law Enforcement	In the past 30 days, the client has been arrested or the family is currently involved or has been investigated by CPS.

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.

Clinician's
Signature _____

Date: _____

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

FSP@state.sd.us or fax 605-773-7076