APPLICATION FOR STATEWIDE FAMILY SUPPORT

(Please print or type)

PARENT/GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ COUNTY: _____ PHONE (best number): _____

EMAIL: _____

NAME OF CHILD(REN) WITH DEVELOPMENTAL DISABILITY	DIAGNOSIS	DOB	SSN	MEDI-CAID Y/N	IEP/IFSP Y/N	RACE	SEX

Documentation of the child's diagnosis and functional limitations such as birth-to-3 evaluations, psychological-educational testing scores or other evaluations pertinent to the child's diagnosis should be submitted. If questions should arise regarding documentation, please call the toll-free number listed below.

Relationship to child with special needs: _____

Does your child with special needs reside in your home? _____ (yes or no)

What is your funding request (optional)? _____
_____
_____

What is the estimated cost (optional)? _____
_____
_____

Briefly describe how this funding will assist your family in meeting your child's special needs: _____
_____
_____
_____

I understand for a child to be eligible for the Statewide Family Support program, he/she must have a diagnosed developmental disability, must be under the age of 22 and must reside within a family member's home. I hereby attest that my child(ren) meets the eligibility requirements for the Statewide Family Support program.

SIGNATURE_____DATE_____

South Dakota Department of Human Services: Statewide Family Support Program
3800 E. Highway 34 - Hillsview Plaza, c/o 500 E. Capitol Ave., Pierre, SD 57501-5070
Phone toll-free 800-265-9684 or 605-773-3438
FAX 605-773-7562, website dhs.sd.gov/dd/family/swfs.aspx