**Section 117.APPENDIX A Preliminary Application forms**

**Section 117.ILLUSTRATION A DMHDD-1235, Home-Based Support Services Program Application**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Illinois Department of Human Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| THE PRELIMINARY FAMILY ASSISTANCE PROGRAM APPLICATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A new program for adults with a severe developmental disability or a severe mental illness. For more information call the Department's toll free number 1-800-843-6154. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please read the brochure before completing items 1-10 below, print or type clearly and sign the application: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 1. | Applicant's name: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 2. | Sex: | | | |  | | Male | | | | | |  | | | | Female | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | 3. | Applicant's race | | | | | | | | | White | | | | |  | | | | Black | | | | | |  | | | | | Hispanic | | | | |  | | | Other | | |  | |
|  | | 4. | Applicant is believed to have: | | | | | | | | | | | | | | | | | |  | | | | severe autism; | | | | | | | | | | | | |  | | severe mental illness; | | | | |
|  | |  |  | | severe or profound mental retardation; | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | severe and multiple impairments. | | | | | | | | | |
|  | | 5. | Applicant's birthdate: | | | | | | | | | | | |  | | | / | |  | | | / | | |  | | |  | | | | | | | | | | | | | | | |
|  | | 6. | Applicant's social security number: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | 7. | Applicant's address: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | City | | | | | | | | | | | | | | | | | State | | | | | | | | Zip | | | | | County | | | |
|  | | 8. | Applicant's telephone number: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | Area code | | | | | | | | | | | | Number | | | | | | | | | | |
|  | | 9. |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | a. | | | The applicant lives in his/her own home/apartment now: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Yes | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | b. | | | The applicant lives outside his/her home now but is a planning to move to his/her own home/apartment if chosen to participate in this program: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Yes | | | | No | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | 10. | Applicant is enrolled in a special education program | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| I declare that the information above is true and I understand that if I am chosen this information will be confirmed by the Illinois Department of Human Services through an assessment to assure my eligibility to participate in the Home-Based Support Services Program. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | |
|  | | Applicant's or guardian signature | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | | | | | | | | | | |
|  | | Guardian's name | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Guardian's telephone number: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Guardian's address: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Section 117.APPENDIX A Preliminary Application forms**

**Section 117.ILLUSTRATION B DMHDD – 1236, Family Assistance Program Application**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Illinois Department of Human Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| THE PRELIMINARY FAMILY ASSISTANCE PROGRAM APPLICATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A new program for adults with a severe developmental disability or a severe mental illness. For more information call the Department's toll free number 1-800-843-6154. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please read the brochure before completing items 1-10 below, print or type clearly and sign the application: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 1. | Child's name: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 2. | Sex: | | | | |  | Male | | | | | | |  | | | | | Female | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | 3. | Child's race | | | | | | | | | White | | | | | |  | | | | | | Black | | | |  | | | | | Hispanic | | | | | | | | | |  | Other | | |  | |
|  | | 4. | I believe my child has: | | | | | | | | | | | | | |  | | | | | severe autism; | | | | | | | | | | | | | | |  | | | | | severe emotional disturbance; | | | | | | |
|  | |  |  | | severe or profound mental retardation; | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | severe and multiple impairments. | | | | | | | | | | |
|  | | 5. | Child's birthdate: | | | | | | | | | | | | |  | | | | / | | |  | | | / |  | | | |  | | | | | | | | | | | | | | | | | |
|  | | 6. | Child's social security number (if available): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
|  | | 7. | Parent's/guardian's Name: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | Street address: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | City | | | | | | | | | | | | | | | | | | | State | | | | | | | | | | | | Zip | | | | | County | | |
|  | | 8. | Parent's/guardian's telephone number: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | 9. | Family taxable income: | | | | | | | | | | | | | | under $50,000 | | | | | | | | | | | | | | | | | | | | | | | over $50,000 | | | | | | | | |
|  | | 10. |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | a. | | | My child lives in the family home now: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | No | | | |
|  | | | b. | | | My child lives outside the family home now, but if I am chosen to participate in this program I plan to bring my child back into the family home: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | Yes | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 11. | Is this a foster child: | | | | | | | | | | | | Yes | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I declare that the information above is true and I understand that if I am chosen this information will be confirmed by the Illinois Department of Human Services through an assessment to assure my eligibility to participate in the Home-Based Support Services Program. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | |
| Parent/guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Date | | | | | | | | | | | | |