Rev. 7/2023

First In Families of North Carolina Application

Internal Use Only
Date Rec'd:
Initials:

1. Family/Household Information

Who is completing this application? ☐Applicant ☐Parent/Guardian ☐Foster Parent ☐Grandparent ☐Other_____

Name_____Email_____ County_____

Address_____ City_____ State_____

Zip_____ Phone_____ ☐ Cell ☐ Home | 2nd Phone_____ ☐ Cell ☐ Home

Secondary Contact_____ Phone_____ Email_____
(Case Mgr, Care Coordinator, etc.) May we talk with them about your application? ☐ Yes ☐ No

How many are living in the home?

Adults:_____ Children/Teens:_____ Adults **over 65**:____ Adults with **disabilities** (18 and up):_____

a. Have you, or anyone in your house, served in the Military? ☐ Yes ☐ No

b. Are you a grandparent raising your grandchildren? ☐ Yes ☐ No

2. Household Income

Income**	How often?
$	☐ Wkly. ☐ Mthly. ☐ Yrly.
Child Support	**How often?**
$	☐ Wkly. ☐ Mthly. ☐ Yrly.
SSDI and/or SSI	**SNAP/Food Stamps/EBT**
$	$

*** Include net income for ALL people in the home.*

3. Information on Individual/Applicant

Name_____

☐ Male ☐ Female ☐ Non-Binary Date of Birth _____/_____/_____

Race ☐ White ☐ Black / African Amer. ☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Multi-Racial ☐ Other

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Residence Type ☐ With Family | ☐ Group Home | ☐ Independently ☐ AFL (Altern. Family Livg.) | ☐ Other

Address (if different) _____

Have you, or anyone in your house, received a diagnosis of a Developmental Disability, Delay, or Traumatic Brain Injury, or Severe and Persistent Mental Illness?

☐ **Yes - Continue to Section 4**
☐ **No - Skip 4, Continue to Section 5**

Which health coverage does the applicant have?

☐ Medicare ☐ Private Insurance ☐ No Insurance
☐ Medicaid (choose Insurance Provider)
☐ AmeriHealth Caritas ☐ Healthy Blue ☐ UnitedHealthcare
☐ Well Care ☐ Carolina Complete Health ☐ Medicaid Waiver ☐ Unsure

4. Disability Diagnosis

Please check any diagnosis(es):

Diagnosis
☐ At Risk for Dev. Delay (Ages 0-3 only)
☐ Developmental Delay (Ages 0-4 only)
☐ Speech Delay
☐ Motor Delay
☐ Autism Spectrum Disorders
☐ Cerebral Palsy
☐ Down Syndrome
☐ Fetal Alcohol Spectrum Disorder
☐ Fragile X
☐ Intellectual Disability
☐ Muscular Dystrophy
☐ Spina Bifida
☐ Traumatic Brain Injury
☐ Severe & Persistent Mental Illness
☐ Substance Use Disorder
☐ Other/Secondary Diagnosis:
How may we verify the diagnosis (required)?

5. Current Services Received

The following services may be available in the community. Please check if you are receiving or on the waiting list for any of the following.

Service	Receive	Waitlist
SNAP/Food Stamps/EBT		
Behavioral Mgmt.		
CAP- C Medicaid Waiver		
CAP- DA Medicaid Waiver		
Innovations/CAP- IDD Medicaid Waiver		
Early Int./Dev. Preschool		
OT/PT/Speech		
Residential Supports		
Respite		
Section 8 Housing		
Special Education		
SSDI		
SSI		
Vocational Rehab.		
TBI Medicaid Waiver		

Have you or anyone in your household experienced a crisis in the past six months? ☐ Yes ☐ No

Currently or within the past 6 months have you or anyone in your household experienced:

☐ Food Insecurity ☐ Interpersonal Violence ☐ Unreliable Transportation ☐ Homelessness

☐ Mental Health Crisis ☐ Major Medical Illness / Expense ☐ Loss of Employment / Income

☐ Cultural / Language Barriers ☐ Death of Caregiver / Household Member ☐ Natural Disaster

☐ Transition from Foster Care, Group Home, Shelter, Prison ☐ Other (please describe): _____

_____

How did you hear about us? Who or which organization referred you? _____

Would you like to receive by email information on future planning resources? ☐ Yes ☐ No

6. What is your need? Provide as much detail as possible, including vendors and prices, if applicable.

_____

_____

_____

_____

_____

_____

_____

_____

May we contact the vendor on your behalf? ☐ Yes ☐ No

WE ENCOURAGE THOSE WE SERVE TO GIVE BACK!

Are there any talents/items you would like to share with First In Families? *(SOME EXAMPLES ARE BELOW)*

☐ Advocacy ☐ Fundraising ☐ Letters to Legislators

☐ Moving Furniture ☐ Handyman/Carpentry Skills ☐ Parent Support

☐ Volunteer (Chapter Projects) ☐ Volunteer (Management Team) ☐ Clothing/Toys/Equipment to donate

☐ Other:

By my signature below, I verify that the above information is accurate. My signature on this application also indicates that I understand that I may receive a survey from First In Families of North Carolina asking me to give feedback on the FIF program. I understand that if I choose to complete the survey, those survey results may be shared (anonymously) with others.

First In Families of North Carolina Notice of Privacy Practices: This notice is effective April 14, 2003.
I acknowledge that I have received a copy of the FIFNC Notice of Privacy Practices.

_____ _____ _____

Print Name Signature of Applicant/Representative Date

CONSENT TO RELEASE INFORMATION

I hereby authorize First In Families of North Carolina to share and receive both written and verbal information regarding the above-named applicant and his/her resource needs. This information will be used for the purposes of identification of resources to meet needs identified by the family/individual.

Such information may include medical, psychological, social and other pertinent information concerning the above named. I understand that this permission shall remain valid for one (1) year from the date of my signature.

However, I may revoke this permission at any time by written notice to First In Families of NC except for action already taken.

Applicant's Name:_____

D.O.B._____

_____ _____

Signature of Applicant/Representative Date

_____ _____

Witness Date