Thank you for contacting First In Families of the Sandhills. FIF of the Sandhills is your local chapter of First In Families of North Carolina, a statewide 501(c)(3) that provides assistance to individuals with Developmental Disabilities (DD) or Traumatic Brain Injury (TBI) and their families. Our mission is to help you and/or your loved one believe in your dreams, achieve your goals, and give back to others.

Enclosed is an application for you to complete and return to our office. When filling out the application we ask that you please be as specific as possible regarding your need for assistance. You can return this application via fax, email, or mail. If you have any questions or need help with the information requested, please call the number below.

Once we receive your application, our resource consultant will contact you within 3 business days to follow up on any missing information and to discuss your request. Due to the volume of applications, we receive and the type of request, please allow FIF at least 30 days to process your application. We will make every effort to address your need as soon as possible. FIF of the Sandhills staff may also need to discuss your (or your family member’s) disability. You may be asked to send additional information regarding the disability to determine whether you are eligible for assistance.

To be eligible for FIF assistance you must:

- Meet the income eligibility based on the household size, see chart below.
- Have a family member living in the home with a developmental delay (ages 0-4) or intellectual/developmental disability or traumatic brain injury; and
- Live in Moore, Hoke, Richmond, Montgomery, Anson, Randolph, Lee, Harnett, or Guilford counties

FIF of the Sandhills uses the NC statute 122-C-3(12a) to define developmental disability. A copy of this statute can be supplied for you if you wish.

Once eligibility is determined, the Resource Consultant will work with you to clearly identify your need and find the sources for assistance. The goal of FIF of the Sandhills staff is to help you find what you need within the community and link you and/or your family member to those resources. This creates a partnership involving you, FIF and the community.

Please return the completed application to:

Christy Adams  
First in Families of the Sandhills  
P.O. Box 773  
Southern Pines, NC 28388  
Phone: 910-692-8272 or 800-909-9272  
Fax: 910-692-4343  
Email: christy@thearcofmoore.org

<table>
<thead>
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<th>Family Size</th>
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<tbody>
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<td>8</td>
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First In Families of the Sandhills Notice of Privacy Practices
This notice is effective April 14, 2003. This notice describes how medical information about you may be used and disclosed and how you can access or request your health information. We are required by law to protect the privacy of medical information about you and that identifies you. We are also required to give you this Notice about our Privacy Practices, explaining our legal duties and your rights concerning your health information. We must follow the privacy practices described in this Notice while it is in effect. We reserve the right to make changes to our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the terms of this Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available on request. You may request a copy of our Notice at any time. If you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact the FIFNC staff at 919-251-8368. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN CERTAIN CIRCUMSTANCES - We use and disclose health information about you for treatment, payment, and healthcare operations. Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Disclosures to You, to Your Family, or to Your Friends: We must disclose your health information to you in accordance with the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you authorize us to do so. Persons Involved in Your Care: We may use or disclose health information to notify, or assist others in notifying a family member, your personal representative or other person responsible for your care, of your location, your general condition, or death. If you are present, we will provide you with an opportunity to object to such disclosures of your health information prior to use or disclosure of that information. In the event you become incapacitated or have a medical emergency, we will disclose your health information based on our professional judgment that such disclosure is directly relevant to that person’s involvement in your healthcare. We will also use our professional judgment and experience to make decisions about your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. Required by Law: We may use or disclose your health information when we are required to do so by law. Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you may be the victim of abuse, neglect, domestic violence or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: May disclose to military authorities the health information of Armed Forces personnel under certain circumstances. May disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances. Appointment Reminders: May disclose health information to provide you with appointment reminders (voicemail messages, postcards or letters). PATIENT RIGHTS - Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make this request in writing to obtain access to your health information. You may obtain a form to request access from your care provider. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. For details about when this request may be denied, please speak with your care provider. Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your health information. (Request must be in writing, and must explain why the information should be amended.) We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail, you are entitled to receive this Notice in written form upon request. QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact your health care provider or FIF of the Sandhills staff at 910-692-8272. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Questions and Complaints → (910-692-8272). Please Keep this Page For your records
First In Families of the Sandhills - Application

Please select one:
☐ Parent  ☐ Applicant  ☐ Guardian

Name______________________________

E-mail______________________________

Address______________________________City_________________________ Zip__________ N.C. County__________

Phone______________________________ ☐ Cell   ☐ Home   ☐ Work

Other Phone___________________________ ☐ Cell   ☐ Home   ☐ Work

1. Family/Guardian/Self-Advocate Household Information

a. How many adults are living in the home?_____
b. How many teens/children are living in the home?_____
c. Are there active/former military living in the home? ☐ Yes ☐ No
d. Are you a grandparent raising your grandchildren? ☐ Yes ☐ No
e. How did you hear about us?__________________________________________$
f. Have you received assistance from us before? ☐ Yes ☐ No

g. Have you experienced a crisis in the past 6 months? (i.e. ER visits, homelessness, domestic violence)? ☐ Yes ☐ No

h. Would you like to be contacted about any future planning questions (wills, special needs trusts, etc.? ☐ Yes ☐ No

i. Would you like assistance in applying for additional benefits you may qualify for? ☐ Yes ☐ No

j. If you do not receive Innovations Waiver services, and are not on the waiting list, would you like a referral to the MCO? ☐ Yes ☐ No

2. Household Income

<table>
<thead>
<tr>
<th>Income**</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>$________</td>
<td>☐ Weekly ☐ Monthly ☐ Yearly</td>
</tr>
</tbody>
</table>

Child Support $________ ☐ Weekly ☐ Monthly ☐ Yearly

SSDI and/or SSI $________ Food Stamps/EBT $________

Parent or guardian employer ___________________________ Position ___________________________

**Total after-tax income for all individuals in the home

3. Information on Individual with the Developmental Disability or Traumatic Brain Injury

Name:_________________________________________

Address:_____________________________________ City_________ State______ Zip__________

(if different from guardian)

<table>
<thead>
<tr>
<th>Male ☐ Female ☐</th>
<th>Date of Birth: <em><strong>/</strong></em>/____</th>
<th>Race/Ethnicity (Optional)*</th>
</tr>
</thead>
</table>

Parent or guardian employer ___________________________ Position ___________________________

Residence type:

☐ At Home ☐ Group Home ☐ Independently ☐ AFL ☐ Other__________________________

*Asked to ensure we reach all racial and ethnic groups in our area

4. Diagnosis

Please check the box(es) for any available diagnosis information.

☐ 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
☐ Atypical
☐ Other/Secondary Diagnosis:

How may we verify the diagnosis?

5. Services

The following services may be available in the community. Please check if you are receiving, on a waiting list, or have been denied any of the following: (Note: If you would like to find out more about the services below or to obtain a referral, please ask the FIF staff or mention this in your request.)

<table>
<thead>
<tr>
<th>Service</th>
<th>No</th>
<th>Receive</th>
<th>Wait</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFDC/WIC/Food Stamps</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Behavioral Mgmt.</td>
<td>☐</td>
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<tr>
<td>CAP-C</td>
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<td>CAP-DA</td>
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<tr>
<td>Innovations Waiver</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Early Int./Dev. Preschool</td>
<td>☐</td>
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<tr>
<td>Medicaid</td>
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<tr>
<td>Medicare</td>
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<tr>
<td>Other insurance</td>
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<tr>
<td>OT/PT/Speech</td>
<td>☐</td>
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<tr>
<td>Residential Supports</td>
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<tr>
<td>Respite</td>
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<tr>
<td>Section 8 Housing</td>
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<tr>
<td>Special Education</td>
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<tr>
<td>SSDI/SSI</td>
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<td>SSI</td>
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<tr>
<td>Vocational Rehab.</td>
<td>☐</td>
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<tr>
<td>Other:</td>
<td>☐</td>
<td>☐</td>
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</table>
May we talk with him/her about your application? □ Yes  □ No

6. Please answer the following questions, attaching extra sheets if you would like:
What is your need? (Please provide as much detail as possible, including vendors and prices if applicable).

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

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.

Print Name________________________ Signature of Parent/Guardian/Self-Advocate________________________ Date________________________

We encourage families to give back. Are there any talents/items you would like to share with First In Families?
□ Advocacy | □ Fundraising | □ Letters to Legislators | □ Moving Furniture | □ Handyman/Carpentry Skills | □ Parent Support
□ Volunteer (Chapter Projects) | □ Volunteer (Management Team) | □ Item donations | □ Other

Consent to Release Information
Applicant’s Name: ______________________ D.O.B.________________________
I hereby authorize First In Families of the Sandhills 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.
□ CDSA (Child Development Service Agency)
□ Local Management Entity
□ Physician(s): __________________________
□ Occupational/Physical/Speech Therapists
□ YM/YWCA
□ School: __________________________
□ Child Care Program: __________________________
□ Other: __________________________
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 earlier time by written notice to First In Families of the Sandhills except for action already taken.

Signature of Parent/Guardian/Self-Advocate________________________ Date________________________
Witness________________________ Date________________________

First In Families of the Sandhills
Notice of Privacy Practices

First In Families of the Sandhills Notice of Privacy Practices - This notice is effective April 14, 2003 I acknowledge that I have received a copy of the FIF Notice of Privacy Practices.

Signature of Parent/Guardian/Self-Advocate________________________ Date________________________

Need help with this application?
Feel free to call our chapter staff at 910-692-8272 or 800-909-9272.

Have you planned for your future?
FIF’s Lifetime Connections program enhances the quality of life and security of individuals with disabilities by building a safety net that can withstand the death of their parents as well as changes in government-funded support services. This includes:
• A dedicated facilitator and support network
• A personal future plan
• Workshops on wills, estate & future planning, and guardianship options
• And much more.
To learn more about Lifetime Connections, call 919.251.8368.
Thank you for your application for services at The Arc of Moore County or First in Families (FIF) of the Sandhills. Please consider the following and check all that apply:

☐ I would like to be added to your email database so that I can receive the quarterly newsletter, The Arc Archives, as well as information about events/happenings through The Arc.

My email address is: ________________________________ (insert email address).

If already on our mailing list, please disregard.

☐ I would like to be contacted regarding annual membership to The Arc.

My mailing address is: ________________________________

______________________________

My phone number is: ________________________________

If already a member or donor, please disregard.

At The Arc, we like to share information about the supports and services we offer with our prospective clients, members and donors. We post information on social media and publish a quarterly newsletter as well. May we contact you about having your story/photos included in these publications?

☐ YES  ☐ NO  Best way to contact you ________________________________

Additional Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please forward copy to PR Dept.

Date Received: ________________  Date Contacted Family: ________________

FIF/Respite Application PR Supplement 2020