

## **FAMILY SUPPORT PROGRAM MODULE**

### **GENERAL INFORMATION**

The Family Support Program assists families who have a child with severe disabilities living at home. The program provides a staff person in each service area to work with families helping them gain access to services and resources they need. In addition, limited funding of up to \$3,000 annually based on an individual family service plan may be available to eligible families to purchase those things that are needed that cannot be purchased through other sources. Family Support funds may be used for a wide range of services and goods based on the unique needs of each family. Parents play a major role in determining what is needed and purchased with FSP funds. The program is designed to meet the needs of the whole family, not just the children with a disability.

Reporting for the Family Support Program is required by s.46.985(3)(f), Wis. Stats. and HSS 65.05(9) Administrative Rules. Data from the reports provides information about the children and families served including the level of need of each child and information about risk factors in the family. In addition, the reporting tracks the use of Family Support dollars and shows other programs that families are using.

Data retrieved from these reports are used in preparation of the annual report for the Family Support Program required by s.46.985(2)(e), to be submitted to the governor and each house of the legislature. In addition, information from the FSP module is used for the purposes of planning for this and other programs serving children with disabilities at both the state and local levels. These data are used in development of county and state budget proposals and are made available upon request to other units of state and county government, community programs, and advocacy groups.

### **REPORTING FREQUENCY**

Data from the FSP module must be entered at least once annually at the close of books after each calendar year. There is no requirement for monthly or semiannual updates, although the option to use the system on a monthly basis is available to counties.

The module provides the option for local agencies to monitor actual expenditures for each family on a monthly basis. An agency could use the system in this way to keep track of individual family and overall program service plans and to plan for expenditure of any unspent funds in the last quarter of the fiscal year.

Case Managers may begin to gather information at the time of the initial assessment and development of the service plan and/or at the six month review date. Basic information regarding the child and family remains on the system from year to year unless changes occur that require the information to be updated. Information that is required to be entered annually at the end of each year are the questions in Fields 28, 29, and 37.

### **Family Support Module Key**

The FSP module key is computer generated and identifies the case (child) and all the information associated with it. As the child is entered for the first time on the Family Support module, the module key will be created and displayed on the screen. This screen may be printed to be used as an updateable document. The module key should be used to enter any changed information on the module. Its primary advantage is that it has fewer characters to enter than the child's name, birthdate, and sex or the Client ID.

**HSRS  
 FAMILY SUPPORT PROGRAM MODULE**

Child and Family Information

**Screen 59 New or 84 Update**

**MODULE TYPE 5**

<b>1</b> Worker ID		<b>2</b> Client ID		<b>3</b> MA Number / Social Security Number	
<b>4a</b> Last Name			<b>4b</b> First Name		<b>4c</b> Middle Name
<b>4d</b> Suffix					
<b>5</b> Birthdate (mm/dd/yyyy)	<b>6</b> Sex F M	<b>7a</b> Hispanic / Latino Y = Yes N = No	<b>7b</b> Race (Circle up to 5) A = Asian B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native W = White		
<b>(Module Key: )</b>					
<b>8</b> Start Date	<b>9</b> End Date	<b>10</b> Closing Reason	<b>11</b> Alternate Care Type (Required if closing reason is 44) 1 Foster care 2 Group home 3 Residential care center 4 Center developmentally disabled 5 Mental health institute 6 Nursing home		
<b>12</b> Client Characteristics	<b>13</b> Diagnosis				
<b>14</b> Assistance Needed for Personal Care 1 Child unable to help him / herself 2 Child needs assistance with some activities 3 Child does not need assistance			<b>15</b> Limitations in Mobility 1 Child cannot walk 2 Child needs assistance in walking 3 Child does not need assistance in walking		
<b>16</b> Limitations in Verbal Skills 1 Child is nonverbal 2 Child has very limited verbal skills 3 Child is fully verbal			<b>17</b> Limitations in Cognitive Abilities 1 Child has severe developmental delays 2 Child has moderate / mild developmental delays 3 Child has no cognitive delays		
<b>18</b> Emotional / Behavioral Issues 1 Child presents significant behavioral challenges 2 Child presents minor behavioral challenges 3 Child has no behavioral challenges			<b>19</b> Medical Needs 1 Apnea monitor 2 Gastrostomy / tube feed 3 Tracheotomy 4 Oxygen dependent 5 Heart monitor 6 Acute psychiatric episode 7 Ongoing medications 8 Degenerative disorder 9 Surgery this year 10 Hospitalization this year		
<b>20</b> Family ID	<b>21</b> Number of Caregivers	<b>22</b> Adopted Child Yes No	<b>23</b> Parent's Special Needs 1 Developmentally disabled 2 AODA 3 Mentally ill 4 Physically disabled 5 Medical condition		
<b>24</b> Income Range 1 0 - 10,000 2 10,001 - 15,000 3 15,001 - 20,000 4 20,001 - 30,000 5 30,001 - 40,000 6 40,001 +					<b>25</b> Family Cost Share

**Screen 79**

**26** Has child returned from alternate care?  
 Yes  No If "Yes" enter alternate care type: 1 Foster care 4 Center for developmentally disabled  
 2 Group home 5 Mental health institute  
 3 Child caring institution 6 Nursing home

<b>27</b> Reporting Year Registration 0000	<b>28</b> Has family considered out of home placement? Yes No	<b>29</b> Is family in a crisis situation? Yes No
	Yes No	Yes No
	Yes No	Yes No
	Yes No	Yes No
	Yes No	Yes No
	Yes No	Yes No

**EXPENDITURES FOR FAMILY SUPPORT SERVICES**

Screen 93 (Module Key: _____ )								30 Next Review Date		
31 Other Programs Used 2 BCPN      4 SSI-E      6 Birth to 3 3 SSI      5 Katie Beckett			32 Voluntary Resources 1 _____ 2 _____					33 Target Group*		
Prog. No.	34 Subprogram	35 Estimated Annual Costs	36 Cost Code A - Add S - Subtract R - Replace	37 Actual Costs	38 Delivery (mm) (yyyy)	39 Service Start Date	40 Service End Date	41 Provider Number		
	A Architectural modification of home									
	B Child care									
	C Counseling / therapeutic resources									
	D Dental and medical care not otherwise covered									
	E Diagnosis and evaluation - specialized									
	F Diet, nutrition and clothing - specialized									
	G Equipment / supplies - specialized									
	H Homemaker services									
	I In-home nursing services - attendant care									
	J Home training / parent courses									
	K Recreation / alternative activities									
	L Respite care									
	M Transportation									
	N Utility costs - specialized									
	O Vehicle modification									
	P Other, as approved by DHFS									

42 Subprogram P, text:

\* Refer to deskcard

**WORKER ID (Field 1)**

OPTIONAL

DEFINITION: The worker collecting the Family Support Program data on the client.

CODES: Enter the ten digit code identifying the person collecting the data on the client.

NOTES: Must be 10 numbers. Must be a valid number from the HSRS worker file, or provider file.

This field is used for the sorting and distribution of output reports.

**CLIENT ID (Field 2)**

REQUIRED, COMPUTER GENERATED

DEFINITION: A unique computer generated identifier for each individual reported on HSRS. Three elements: full legal name, birthdate, and sex produce a fourteen character identifier which bears no resemblance to the client's name.

CODES: Leave blank if name is reported.

**OR**

Enter the 14 character HSRS Client Identification Number - one letter followed by 13 numbers.

The ID will be generated and returned to you on the terminal screen. Copy ID down or print out the screen. Once the ID number is generated, use it on all future input.

**MA OR SOCIAL SECURITY NUMBER (Field 3)**

REQUIRED, IF APPLICABLE; SOCIAL SECURITY NUMBER IS OPTIONAL.

DEFINITION: The Medical Assistance identification number or Social Security number which has been assigned to this client.

CODES: Enter the client's 10 digit Medical Assistance number or the 9 digit Social Security number.

NOTES: If the child is eligible for Medical Assistance, enter the MA number.

Enter the Social Security number only when the MA number is not available.

**NAME - LAST, FIRST, MIDDLE, SUFFIX (Fields 4a, 4b, 4c, 4d)**  
REQUIRED TO GENERATE ID (THEN OPTIONAL)

DEFINITION: The full legal name of the child. Nicknames, abbreviations or other variations should not be used.

CODES: Enter the full legal name of the child. If the client has no legal first name, enter the word None; if no middle name and/or suffix, leave blank.

NOTES: Must be all letters. Last name limited to 35 letters. First name limited to 25 letters. Middle name limited to 25 letters or blank. Suffix limited to 10 letters or a blank. No apostrophes, hyphens, slashes, dashes or spaces between letters, or any other punctuation marks are accepted.

**BIRTHDATE (Field 5)**  
REQUIRED

CODES: Enter the 8 digit birthdate of the client using month/day/full year. Example - June 3, 1980 is 06032004.

NOTES: Clients over age 24 are not allowed in the program.

**SEX (Field 6)**  
REQUIRED

CODES: F = Female  
M = Male

**HISPANIC/LATINO (Field 7a)**  
REQUIRED

DEFINITION: All persons of Mexican, Puerto Rican, Cuban, Central or South American, or another Spanish culture or origin, regardless of race.

CODES: Y = Yes  
N = No

**RACE (Field 7b)**  
REQUIRED

DEFINITION: The race of the client as determined by the client. Code as many as apply up to all five.

CODES: A = Asian  
B = Black or African American  
W = White  
P = Native Hawaiian or Pacific Islander  
I = American Indian or Alaska Native

**Asian:** All persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**Black or African American:** All persons having origins in any of the black racial groups of Africa.

**White:** All persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

**Native Hawaiian or Pacific Islander:** All persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. (The term Native Hawaiian does not include individuals who are native to the State of Hawaii by virtue of being born there.)

**American Indian or Alaska Native:** All persons having origins in any of the original peoples of North, South and Central America.

**START DATE (Field 8)**  
REQUIRED

DEFINITION: The date when the Family Support case was opened.

CODES: Enter an 8 digit number in the format of month/day/full year.

NOTES: The date the agency chooses to enter may be the date of the initial needs assessment, the date the family signs the service plan agreement or the date that services actually begin. The service manager has the option to choose whichever date is useful for records.

**END DATE (Field 9)**  
REQUIRED

DEFINITION: The date the Family Support case is closed.

CODES: Enter the 8 digits representing the month/day/full year the case was closed.

NOTES: Must be 8 digits; must be earlier than or equal to the current date.

**CLOSING REASON (Field 10)**  
REQUIRED

DEFINITION: The reason the case is being closed.

CODES: Enter the code that best describes why the client will no longer receive FSP funded services.

- 06 Death of a child
- 36 Insufficient funds to provide needed services
- 37 Child at home but family doesn't need services
- 38 Family no longer wants service
- 40 Temporary interruption in Family Support service
- 42 Family referred to other program(s)
- 43 Family relocated
- 44 Child placed in alternate care
- 45 Child no longer meets eligibility
- 46 Child transitions to adult living arrangement

NOTES: Must be one of the above codes. Initial entries (new) cannot be zeros (00). Zeros (00) can only be used to update previously entered codes for the purpose of reopening the case.

**ALTERNATE CARE TYPE (Field 11)**  
REQUIRED, WHEN CODE 44 IN FIELD 10 IS ENTERED.

DEFINITION: The type of alternate care in which the child is placed at termination of FSP services.

- CODES:
- 1 = Foster care
  - 2 = Group home
  - 3 = Residential care center
  - 4 = Center for developmentally disabled
  - 5 = Mental health institute
  - 6 = Nursing home

## **CLIENT CHARACTERISTICS (Field 12)**

### **REQUIRED**

**DEFINITION:** Describes the client according to selected personal, social, and demographic factors that are of interest to the agency. Code as many as apply up to three. Code definitions are in Appendix I.

**CODES:** Enter up to three codes from the list below that best describe the child.

- 07 Blind/visually impaired
- 08 Hard of hearing
- 32 Blind/deaf
- 79 Deaf
- 09 Physical disability/mobility impaired
- 85 Severe health impairments
- 86 Severe emotional disturbance
- 02 Mental illness (excluding SPMI)
- 03 Serious and persistent mental illness (SPMI)
- 19 Developmental disability - brain trauma
- 23 Developmental disability - cerebral palsy
- 25 Developmental disability - autism spectrum
- 26 Developmental disability - mental retardation
- 27 Developmental disability - epilepsy
- 28 Developmental disability - other or unknown
- 61 CHIPS - abuse and neglect
- 62 CHIPS - abuse
- 63 CHIPS - neglect

**NOTES:** At least one code must be entered in the first space. The code representing the client's primary need should be put in the first position.

## **DIAGNOSIS (Field 13)**

### **OPTIONAL**

**DEFINITION:** The disability of the child as described by the physician.

**CODES:** Enter in narrative form the physician's description of the child's disability(ies). Enter up to 30 characters.

**ASSISTANCE FOR PERSONAL CARE (Field 14)**  
REQUIRED

DEFINITION: The level of assistance required by the child to perform self-care skills such as bathing, feeding, toileting. Ability to perform tasks related to self-care should be considered in relation to what is normally considered appropriate to the child's age.

CODES: Enter one code from the list below which best describes the level of care needed by the child.

- 1 Child unable to help him/herself
- 2 Child needs assistance with some activities
- 3 Does not need assistance

**LIMITATIONS IN MOBILITY (Field 15)**

DEFINITION: The level of assistance required by the child to perform gross motor activities which are considered appropriate to the child's age. For a child above 2 years old, gross motor activities can be measured by the ability to walk.

CODES: Enter one code from the list below which best describes the level of care needed by the child in performing gross motor activities.

- 1 Child cannot walk
- 2 Child needs assistance in walking
- 3 Does not need assistance in walking

NOTES: The use of the lay person's description of walking for gross motor activities is maintained in the codes as a shorthand for describing problems that occur when children are unable or delayed in physical development. For infants and toddlers, such physical delays or problems should also be coded in this shorthand. For example, if a child under 2 is able to perform gross motor skills appropriate to the child's age and the expectation is that the child will be able to walk by about age 2, enter code 3 (does not need assistance in walking).

**LIMITATIONS IN VERBAL SKILLS (Field 16)**  
REQUIRED

DEFINITION: The ability to communicate vocally at a level appropriate to the child's age.

CODES: Enter one code from the list below which best describes the level of verbal ability of the child.

- 1 Child is nonverbal
- 2 Child has very limited verbal skills
- 3 Child is fully verbal

NOTES: If a child is under 2 years old and uses age appropriate sounds to communicate (such as crying or cooing), enter code number 3 - child is fully verbal, meaning that communication is appropriate to the child's age level.

**LIMITATIONS IN COGNITIVE ABILITIES (Field 17)**  
REQUIRED

DEFINITION: The ability to function intellectually concurrent with adaptive behavior. A generalized understanding of cognitive abilities is based on major considerations for determination of mental retardation used by the public schools.

CODES: Enter one code from the list below which best describes the level of cognitive ability of the child.

- 1 Child has severe developmental delays
- 2 Child has moderate/mild developmental delays
- 3 No cognitive delays

NOTES: For children under the age of 3, cognitive delays may be measured by developmental milestones appropriate to the age of the child.

**EMOTIONAL/BEHAVIORAL ISSUES (Field 18)**

REQUIRED

DEFINITION: Emotional, social, and behavioral functioning that significantly interferes with the child's development including learning and developing skills in social interactions and interpersonal relationships.

CODES: Enter one code from the list below which best describes the emotional/behavioral condition of the child.

- 1 Child presents significant behavioral challenges
- 2 Child presents minor behavioral challenges
- 3 No behavioral challenges

**MEDICAL NEEDS (Field 19)**

REQUIRED, WHEN APPLICABLE

DEFINITION: The child has a condition which requires medical interventions including the ongoing use of technological supports and/or medications.

CODES: Enter up to 6 applicable codes from the list below which describe the medical interventions used to assist the child.

- 1 Apnea monitor
- 2 Gastrostomy/tube feed
- 3 Tracheotomy
- 4 Oxygen dependent
- 5 Heart monitor
- 6 Acute psychiatric episode
- 7 Ongoing medication
- 8 Degenerative disorder
- 9 Surgery this year
- 10 Hospitalization this year

**FAMILY ID (Field 20)**

REQUIRED, WHEN THERE IS MORE THAN ONE CHILD WITH DISABILITIES IN THE FAMILY.

DEFINITION: An agency assigned number that will link family members together.

CODES: Enter up to 7 agency assigned characters. Both numbers and letters are accepted. Use an A as the final character in a Family ID to designate that client as the one the entire family will be grouped under on output reports. All other clients in a given family grouping should be given the same Family ID but ending with a B.

NOTES: If there is more than one case manager in the agency, the Family Support Program coordinator or the case management supervisor should assign the numbers to all families who have more than one disabled child to avoid duplication of numbers for different families.

**NUMBER OF CAREGIVERS (Field 21)**

REQUIRED

DEFINITION: The number of people in the household who are responsible for caring for the child with disabilities.

CODES: Enter either 1 or 2.

NOTES: Usually those people considered responsible for the child are the parents. If only one parent is in the home and available for the care of the child overall, then enter 1. If there are two parents or surrogate parents, enter 2.

**ADOPTED CHILD (Field 22)**

REQUIRED

DEFINITION: The child has been adopted or will be adopted in the next 6 months by the family with whom the child is living.

CODES: Y = Yes  
N = No

NOTES: If the child is with natural parents code No.

**PARENTS' SPECIAL NEEDS (Field 23)**

REQUIRED, WHEN APPLICABLE.

DEFINITION: Conditions of the parent or parents which make the care of a child with disabilities difficult or more complicated.

CODES: Enter up to 3 applicable codes from the list below which describe the condition of one or both parents.

- 1 Developmentally disabled
- 2 Alcohol and other drug abuse
- 3 Mentally disabled
- 4 Physically disabled
- 5 Medical condition

NOTES: One or more codes may be entered regardless of whether or not the parent is receiving services as a result of their special needs.

**INCOME RANGE (Field 24)**

REQUIRED

DEFINITION: The annual income of the parent(s) responsible for the care of the child. Assets are not included.

CODES: Enter the range of income in which the family falls on the list below.

- 1 \$ 0 - 10,000
- 2 \$10,001 - 15,000
- 3 \$15,001 - 20,000
- 4 \$20,001 - 30,000
- 5 \$30,001 - 40,000
- 6 \$40,001 +

NOTES: The income of the family will be recorded on line 14 of the Ability to Pay - Worksheet 1, when this cost sharing form, DDE-939, is completed for the family.

**FAMILY COST SHARE (Field 25)**

REQUIRED, WHEN APPLICABLE.

DEFINITION: The family's annual share of the cost of Family Support services.

CODES: Enter up to 5 digits representing the whole dollar amount that is the family's annual share of the cost of Family Support services.

NOTES: The family's cost share will be recorded either on line 22 or line 26 of the Ability to Pay - Worksheet 1, DDE-939. The system defaults to zero.

**HAS CHILD RETURNED FROM ALTERNATE CARE? (Field 26)**  
REQUIRED, AT THE TIME OF REGISTRATION

**DEFINITION:** The alternate care placement history of the child this last year or sometime in the past. The child has returned from an out of home placement in a foster home, group home, or residential care center or from a state center for the developmentally disabled, a mental health institute, or nursing home.

**CODES:** Y = Yes  
N = No

If Yes is entered, enter one code from the list below which describes the type of alternate care from which the child has returned.

- 1 Foster care
- 2 Group home
- 3 Residential care center
- 4 Center for developmentally disabled
- 5 Mental health institute
- 6 Nursing home

**NOTES:** At registration record the alternate care placement history. If the child has **ever** been placed in alternate care in the year prior to registration or anytime in the past, enter Yes and the type of alternate care used.

**REPORTING YEAR (Field 27)**  
REQUIRED

**DEFINITION:** This field identifies the year for the questions in Fields 28 and 29, and is to be used at the time of registration and each year for year end reporting.

**CODES:** Enter the 4 digit year only, not month and day.

**NOTES:** Registration year is shown as 0000. The questions for registration are answered at the time a family enters the program. Once a family is participating in the program, the questions should be answered at the end of each year in which the family has received services. If a family starts the program in June 2006, questions in 28 and 29 would be answered both at the time of registration (year 0000) and then the end of service year (2006).

**HAS THE FAMILY CONSIDERED OUT OF HOME PLACEMENT? (Field 28)**  
REQUIRED, AT REGISTRATION AND THE END OF EACH CALENDAR YEAR.

DEFINITION: The family has talked about the possibility that they might be unable to maintain the child at home and therefore, have thought about placing the child in alternate care.

CODES: Y = Yes  
N = No

At the time of registration, enter Yes if the parents have expressed concern at that time or sometime in the past that they may need to place the child. (Yes may be entered even if the parents have not sought admission to out of home placement for the child.) In subsequent years answer the question for each year at the end of the reporting year.

**IS THE FAMILY IN A CRISIS SITUATION? (Field 29)**  
REQUIRED, AT REGISTRATION AND THE END OF EACH CALENDAR YEAR.

DEFINITION: A period of time marked by high stress in the family. The stress may be caused by one or a number of factors including but not limited to: marital problems, poverty, single parent caring for child, more than one child with disability, child has a terminal condition, etc. The stress may be exaggerated by circumstances such as illness, birth of a child, divorce, etc. Worker judgment should be used in determining whether the family is experiencing crisis at the time of entry to the program or during the reporting year.

CODES: Y = Yes  
N = No

NOTES: At registration enter Yes if the family was experiencing crisis at the time of entry to the program or anytime in the past. In subsequent years enter Yes if the family was experiencing crisis during the reporting year.

**NEXT REVIEW DATE (Field 30)**  
OPTIONAL

DEFINITION: Date when the case review or other agency activity is due to take place.

CODES: Enter the 8 digit date in the format month/day/full year.

**OTHER PROGRAMS USED (Field 31)**

REQUIRED, WHEN APPLICABLE.

DEFINITION: Service and programs used by the family, other than Family Support, during the reporting year.

CODES: Enter all applicable codes from the list below which show the programs for which the child and/or family is eligible during all or part of the reporting year.

2	BCPN	Bureau for Children With Physical Needs
3	SSI	Supplemental security income
4	SSI-E	SSI with the exceptional rate
5	Katie Beckett	Medical Assistance (MA) without regard to the income of parents
6	Birth to 3	Early intervention program for children ages birth to 3 years

NOTES: Only one SSI program may be coded, not both.

**VOLUNTARY RESOURCES (Field 32)**

OPTIONAL

DEFINITION: Voluntary community resources used to assist the family other than Family Support services and the programs listed under OTHER PROGRAMS USED.

CODES: Enter up to 2 written descriptions of other resources used. Enter up to 20 characters in each description.

NOTES: Examples of voluntary community resources include Easter Seals, church fund raisers, telethon, etc. Do not list other public programs such as public school special education or county provided services such as Respite or Birth to 3 early intervention. Do not list private insurance.

**TARGET GROUP (Field 33)**

REQUIRED - THE FIRST TIME A REPORT IS FILED FOR THE PARTICIPANT, WHEN A SUBPROGRAM IS ADDED, AND WHENEVER THERE IS AN UPDATE TO TARGET GROUP.

DEFINITION: Indicates the need and/or problem that best explains the primary reason the child is receiving services.

CODES: 01 Developmental disability  
31 Mental health  
57 Physical or sensory disability

NOTES: Enter appropriate code the first time a report is made for a Family Support participant and whenever there is an update.

The code definitions can be found in the HSRS CORE Target Group section of this handbook.

**SUBPROGRAM (Field 34)**

REQUIRED - ANNUALLY FOR EACH SUBPROGRAM IN WHICH SERVICES WERE DELIVERED TO THE FAMILY.

DEFINITION: The services used by the family that are funded by Family Support.

CODES: Use the line on the form with the appropriate subprogram.

A Architectural modifications of home  
B Child care  
C Counseling/therapeutic resources  
D Dental/medical care not otherwise covered  
E Diagnosis and evaluation - specialized  
F Diet, nutrition, and clothing - specialized  
G Equipment/supplies - specialized  
H Homemaker services  
I In-home nursing services/attendant care  
J Home training/parent courses  
K Recreation/alternative activities  
L Respite care  
M Transportation  
N Utility costs - specialized  
O Vehicle modification  
P Other as approved by DHFS

NOTES: Services/subprograms default to SPC 111 Family Support.

## **SUBPROGRAM CODE DEFINITIONS**

The Family Support Program provides funding to families to purchase supportive services and goods not covered through other funding sources. The program is based on the belief that parents of children with severe handicaps know their own needs and those of their disabled child. For this reason, and because of the individuality of each family, goods and services available through the program have been very broadly defined, leaving considerable leeway for families to choose whatever will help to maintain the child in their home. Any service, or any portion of a service, that is documented as needed in a family's service plan, and that is approved by the administering agency, may be funded within the following categories:

- A Architectural Modifications of the Home - Examples include ramps, door widening, room additions, room divider, stairglide, backyard fence, bathroom modifications for accessibility, ceiling lift system, elevator parts, pulley for outdoor ramp.
- B Child Care - For example, after school programs, child day care costs, or a family's share of such costs, child care for siblings so parents could spend time alone with their child who has a disability.
- C Counseling/Therapeutic Resources - For example, occupational, physical, speech and behavior management therapies for the child with disabilities, other counseling and therapeutic resources for the child and other family members.
- D Dental/Medical Care Not Otherwise Covered - For example, costs for dental care not covered by the family's insurance or Medical Assistance, costs for insurance premiums.
- E Diagnosis and Evaluation-Specialized - For example, specialized diagnosis or evaluation of the child, genetic counseling for the parents and siblings.
- F Diet, Nutrition, and Clothing-Specialized - For example, specially prepared foods, specially made clothes and footwear, also includes clothes needing replacement often due to the child's special needs.
- G Equipment/Supplies-Specialized - For example, equipment personal to the child such as positioning boards and special chairs, water or hospital beds, computers or communication boards, and also specialized household equipment such as an air conditioning unit or air purifier to help a child who has breathing problems, intercom for nap or nighttime monitoring, etc. Also includes equipment to help the child participate in family activities such as a large bicycle trailer or car seats so the child can attend family outings.
- H Homemaker Services - Examples include home chores, cooking, cleaning and managing finances.
- I In-Home Nursing Services/Attendant Care - For example, help in feeding a child who requires four hours a day to feed, attendant services for a young adult, help with bathing.
- J Home Training/Parent Courses - Includes training provided to parents in or out of the home, for such things as behavior management, advocacy for the child, helping the child to toilet train, teaching therapy skills, etc.
- K Recreation/Alternative Activities - Includes primarily those activities aimed at the social integration of the child. For example, fees for community recreation programs, scouting programs and may also include recreation opportunities for the family as a whole. Examples are family membership in the local YMCA or Boys Club and program fee for family recreation or camping.

## **SUBPROGRAM CODE DEFINITIONS - continued**

- L Respite Care - Includes services provided in or out of the home to relieve the parents of the continued stress of caring for the child. May also include recreational activities of the family with the child (e.g., if a family is unwilling to leave their child in another's care because of the child's special needs, respite may be purchased for the family as a whole).
- M Transportation - Includes gas (or mileage), food and lodging, which follows standard county or state guidelines for use. Transportation may be used for trips to doctors, local recreation programs and other community activities.
- N Utility Costs-Specialized: Includes long-distance telephone calls to doctors and other resources, supplemental heating and air conditioning costs.
- O Vehicle Modification - For example, van lifts, ramps, tie-downs.
- P Other Goods and Services - Services or goods requested by families generally will fit within the fifteen categories specified above. However, if a family requests a service or item which does not fit these categories, the agency may request approval for the family's request from the state Developmental Disabilities Office.

Any of these services may be funded fully or in part with Family Support dollars. Funds may be coupled with resources from other programs or with the family's own resources. For example, the program may provide funding for materials to build a small indoor elevator, while family members provide the carpentry and electrical work. Another example is the purchase of high cost items such as room additions or vehicles. It is possible to use a combination of funding sources for these purposes such as Community Options Program, Family Support and the family's own resources. On the expenditure form, however, record only the estimated and actual costs to the Family Support Program.

### **ESTIMATED ANNUAL COST (Field 35)**

#### OPTIONAL

**DEFINITION:** From the initial needs assessment, the estimated annual dollar amount that would be needed from the Family Support Program in each subprogram category for the service requested.

**CODES:** Enter up to 4 digits representing the whole dollar amount estimated as needed for services in the specific subprogram categories.

**NOTES:** Enter at the time of the initial assessment and development of the service plan. May be used to track actual expenditures against the original budget amount.

### **COST CODE (Field 36)**

#### REQUIRED TO ADJUST ACTUAL COSTS ON AN ANNUAL OR MONTHLY BASIS.

**DEFINITION:** The function used to complete current actual costs in any subprogram category.

**CODES:** A = Add  
S = Subtract  
R = Replace

**NOTES:** A - For the first time entry of monthly or annual costs, use the add code to enter the amount.  
Also use the add code if additional costs are to be entered for the month (or year) when a previous entry had been made. Enter the additional costs.

S - Use the subtract code if services are subsequently reimbursed through some other source after Family Support payments have been made. Enter the amount of the reimbursement.

R - Replace is used if a new entry is made for a month or year to **replace** the old value.

**ACTUAL COST (Field 37)**

REQUIRED ANNUALLY, WITH OPTIONAL MONTHLY RECORDING CAPABILITY.

DEFINITION: The total actual expenditures of Family Support Program dollars in each subprogram category.

CODES: Enter up to five whole numbers and two decimal places representing the dollar amount actually expended for service in applicable subprogram categories.

NOTES: Actual expenditures may be reported and updated on a monthly basis, or a total dollar amount in each subprogram category may be reported once at the close of the reporting year. If monthly reporting is begun for a year, and a change to annual reporting for that same year is made, the monthly costs must be zeroed out before annual cost amounts can be entered and vice versa.

If there is more than one child in a family, enter actual expenditures for **family** needs only on the report of the child whose Family ID number (Field 22) uses A as the final character. Do not duplicate expenditure reports on each child's form.

If the child is also in the LTS program with Family Support match funding, report the total costs on both the FSP and LTS modules.

**DELIVERY, MONTH AND YEAR (Field 38)**

REQUIRED

DEFINITION: The month and full year in which the entered costs were incurred.

CODES: Enter 6 digits representing the month and full year.

NOTES: The date should coincide with the month and year in which expenditures were authorized. If funds are authorized at the end of a calendar year for expenditures during that year, date the actual expenditures in that year even if payments are finally made in January or February of the following year.

**Leave the month field blank** if entering total annual costs and not using the optional monthly feature.

**SERVICE START DATE (Field 39)**

OPTIONAL

DEFINITION: The date that Family Support funded services began under the subprogram.

CODES: Enter the 8 digit date representing the month/day/full year that Family Support funded services began.

**SERVICE END DATE (Field 40)**

OPTIONAL

DEFINITION: The date Family Support funding for services ceased for the subprogram.

CODES: Enter the 8 digits representing the month/day/full year all funding for services ceased.

NOTES: Must be 00000000 or later than or equal to the service start date. (00000000 is used to reopen a closed subprogram.)

**PROVIDER NUMBER (Field 41)**

OPTIONAL

DEFINITION: The number assigned to identify the reporting unit, facility, or person that has delivered the subprogram to the family.

CODES: Enter the 10 digit HSRS code identifying the provider of the specific subprogram.

**SUBPROGRAM P TEXT (Field 42)**

REQUIRED, WHEN CODE P IN FIELD 34 IS ENTERED.

DEFINITION: The type of service or goods that have been provided to the family in the OTHER category of subprograms.

CODES: Enter in narrative form a brief description of the services or goods purchased. Enter up to 75 characters.

NOTES: If more than one type of service is used in the OTHER category, the services may be listed, separated by a comma. If services in this category are added at a later time the initial services(s) must be re-entered or they will be replaced by subsequent entries.