

**Family Support Services – Application and Request for Funds – 2026**

**\*ALL requests must have prior approval BEFORE purchases are made\***

**\*\*Send Requests to [familysupport@putnamdd.org](mailto:familysupport@putnamdd.org)\*\***

Name of Eligible Individual: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Name of Family Member: \_\_\_\_\_ Relation to Individual: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_

**Special Equipment/Service Request**

- Description: \_\_\_\_\_
- Professional recommendation from: \_\_\_\_\_
- Supplier/Provider: \_\_\_\_\_
- Estimated Cost: \_\_\_\_\_

**Respite Services Request**

- Number of hours/days: \_\_\_\_\_ Planned dates: \_\_\_\_\_
- Estimated cost (\$6.25/hour, maximum of \$75/day): \_\_\_\_\_
- Name of requested provider: \_\_\_\_\_

**\*We are requesting the PCBDD to waive a background investigation for this provider. We are assured that this care is acceptable and provides for the safety and needs of our family, including all medical and transportation concerns. We assume all responsibility and liability for the selection of this provider.**

**Medical Mileage Request** – Calculated at the current IRS mileage rate

- Location of expected medical travel: \_\_\_\_\_
- Total miles of expected travel: \_\_\_\_\_ Expected travel dates: \_\_\_\_\_
- Estimated Cost: \_\_\_\_\_

**Other Request:** \_\_\_\_\_

- Professional recommendation from: \_\_\_\_\_

**\*\*Families should attempt to access other sources prior to Family Support Services. Family Support Services is the payer of last resort. If private insurance, BCMH, or JFS funding is available, they must be used before utilizing PCBDD funding. I verify that Family Support Services is being utilized as the Payer of Last Resort.**

\_\_\_\_\_  
 Family Member Signature \_\_\_\_\_  
 Date

\*\*\*\*\*

**Office Use:**

Recommend to:    \_\_\_ Approve    \_\_\_ Not Approve; Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of reviewer \_\_\_\_\_ \* Date \_\_\_\_\_

\*Signature confirms all requirements have been met as listed under Section 3.0 of PCBDD FSS Grant policies.