

APPENDIX II

IN-HOME SUBSIDY REQUEST / APPROVAL FORM

Requested by: \_\_\_\_\_ APD Area Office: \_\_\_\_\_  
(applicant)

SS #: \_\_\_\_\_

Check one:  
REQUEST FOR START-UP GRANT \_\_\_\_\_  
MONTHLY IN-HOME SUBSIDY \_\_\_\_\_  
EMERGENCY IN-HOME SUBSIDY \_\_\_\_\_

Based on the completed Financial Profile, a one-time start up subsidy is requested in the amount of:  
\$ \_\_\_\_\_

Based on the completed Financial Profile, a recurring monthly subsidy is requested in the amount of  
\$ \_\_\_\_\_

Based on an emergency situation, a one-time emergency subsidy is requested in the amount of  
\$ \_\_\_\_\_

The in-home subsidy is requested for the following specific purpose: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Explain the nature of the emergency: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signatures:**

	<u>Approve</u>	<u>Disapprove</u>	<u>Signature</u>
Supported Living Coach:	_____	_____	_____
Support Coordinator:	_____	_____	_____
Area Office Administrator: (or designee)	_____	_____	_____

Make In-Home Subsidy Payable to:  
\_\_\_\_\_  
(applicant or fiscal agent/representative payee)

APPENDIX III

SAMPLE AGREEMENT TO PAY SUPPORTED LIVING IN-HOME SUBSIDY

This Agreement is made between the Agency for Persons with Disabilities (hereinafter referred to as the "Agency"), and \_\_\_\_\_, or \_\_\_\_\_ as fiscal agent/representative payee for \_\_\_\_\_.

In addition to the services funded through the HCBS Medicaid Waiver, the Agency agrees to pay, pursuant to Florida Statute 393.0695 (a copy of which is attached), a:

- 1. A monthly subsidy in the amount of \$\_\_\_\_\_ per month, for the period of \_\_\_\_\_ through \_\_\_\_\_.
2. A one time subsidy in the amount of \$\_\_\_\_\_.

This subsidy is to be used to pay for the needs identified in the approved request for an in-home subsidy, for \_\_\_\_\_ and is intended to address community related needs which cannot be paid through the HCBS Medicaid Waiver. A specific list of items approved is found in the In-home Subsidy Request / Approval Form attached to this agreement.

Subsidies, as with all programs funded within the Agency, are paid based upon "availability of funds" and justification of need. If monies are not available, funds cannot be disbursed. Further, subsidies are paid based upon the financial and service needs of the Agency's clients, with the understanding that all other sources of assistance have been explored, developed and executed. The subsidy request will be reviewed during the last month of the agreement to justify its continuance. It is understood that the subsidy is not entitlement and may be increased, decreased or terminated at any time.

In witness thereof, the parties have caused this one page agreement to be executed by their undersigned official as duly authorized.

Applicant (print name): \_\_\_\_\_
By (signature): \_\_\_\_\_
Relationship: \_\_\_\_\_
Date: \_\_\_\_\_

State of Florida, Agency for Persons with Disabilities
By (signature): \_\_\_\_\_
Title (Program Administrator or designee): \_\_\_\_\_
Date: \_\_\_\_\_